Integrated Health Project in Burundi (IHPB)

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Year 3 Report

October 1, 2015 – September 30, 2016

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Table of Contents

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ABUBEF	*Association Burundaise pour le Bien Etre Familial*
ACTs	Artemisinin-based Combination Therapy
ADBC	*Agent Distributeur à Base Communautaire* (Community Based Distributor of Contraceptives)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ANSS	*Association Nationale de Soutien aux Séropositifs et aux Sidéens*
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BDS	*Bureau du District Sanitaire* (District Health Bureau)
BEmONC	Basic Emergency Obstetric and Newborn Care
BMCHP	Burundi Maternal and Child Health Project
BPS	*Bureau Provincial de la Santé* (Provincial Health Bureau)
BRAVI	Burundians Responding Against Violence and Inequality
BTC	Belgian Technical Cooperation
CAM	*Carte d'Assistance Médicale* (Health Assistance Card)
CBD	Community Based Distribution
CBO	Community-Based Organization
C-Change	Communication for Change
CCM	Community Case Management
CCT	Community Conversation Toolkit
CD4	Cluster of Differentiation #4
CFR/OMB	Code of Federal Regulations/Office of Management and Budget
CHW	Community Health Worker
CLIN	Cost Line Item Number
CoP	Chief of Party
COP	Country Operational Plan
COPED	*Conseil Pour l'Education et le Développement*
COSA	*Comité de Santé*
CPSD	*Cadre de Concertation pour la Santé et le Développement*
CPVV	*Comité Provincial de Vérification et de Validation*
CRDBi	Centre de Recherche de Virologie et de Diagnostic Biologique
CS	Capacity Strengthening
CSM	Community Services Mapping
CSO	Civil Society Organization
CTN	*Cellule Technique Nationale*
CT FBP	*Cellule technique du Financement Basé sur la Performance*
DATIM	Data for Accountability, Transparency and Impact
DBS	Dried Blood Spot testing
DCOP	Deputy Chief of Party
DHE	District Health Educator
DHIS	District Health Information System
DHS	Demographic and Health Survey

DHT	District Health Team
DPE	*Direction Provinciale de l'Enseignement*
DPSHA	*Département de Promotion de la Santé, Hygiène et Assainissement*
DQA	Data Quality Assurance
EC	Emergency Contraception
EID	Early Infant Diagnostic
EONC	Emergency Obstetric and Neonatal Care
ENA	Emergency Nutrition Assessment
FAB	Formative Analysis and Baseline Assessment
FGD	Focus Group Discussion
FHI 360	Family Health International
FFP	Flexible Family Planning Project
FP	Family Planning
FQA	Facility Qualitative Assessment
FSW	Female Sex Worker
FTO	Field Technical Officer
GBV	Gender-Based Violence
GoB	Government of Burundi
HBC	Home-Based Care
HC	Health Center
HD	Health District
HH	Household
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Technician
HIS	Heath Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HO	Home Office
ICASA	International Conference on HIV/AIDS and STIs in Africa
iCCM	Integrated Community Case Management
IDI	In-Depth Interview
IEC	Information, Education and Communication
IHPB	Integrated Health Project in Burundi
INGO	International Non-Governmental Organizations
IP	Implementing Partner
IIP	Institutional Improvement Plan
IKG	In-Kind Grant
IMC	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment of malaria during Pregnancy
IPC	Interpersonal Communication
IRB	Institutional Review Board
ISTEEBU	*Institut de Statistiques et d'Etudes Economiques du Burundi*
ITN	Insecticide-Treated Net
IYCF	Infant Young Child Feeding

Kfw	Kreditanstalt für Wiederaufbau (Établissement de crédit pour la reconstruction) Allemand (German Development Bank)
KII	Key Informant Interview
KP	Key Populations
LMIS	Logistics Management Information System
LOE	Level of Effort
LOP	Life of Project
LPT	Local Partner Transition
M&E	Monitoring and Evaluation
MESAT	M&E System Assessment
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MOP	Malaria Operational Plan
MoU	Memorandum of Understanding
MPHFA	Ministry of Public Health and Fight against AIDS
MSM	Men having Sex with Men
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
NHIS	National Health Information System
NPAC	National Program for AIDS/STIs Control
NMCP	National Malaria Control Program
NGO	Non-Governmental Organization
NUPAS	Non- US Organization Pre-Award Survey
OIRE	Office of International Research Ethics
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PCR	Polymerase Chain Reaction
PDSA	Plan-Do-Study-Act
PECADOM	*Prise en Charge à domicile* (Community Case Management)
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PHSC	Protection of Human Subjects Committee
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMEP	Performance Monitoring & Evaluation Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNILP	*Programme National Intégré de Lutte contre le Paludisme*
PNLS	*Programme National de Lutte contre le SIDA*
PNSR	*Programme National de Santé de la Reproduction*
PPP	Public-Private Partnership
PRONIANUT	National Food and Nutrition Program
PTO	Program & Technical Officer
QA/QI	Quality Assurance/Quality Improvement
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team

RBP+	*Réseau Burundais des Personnes vivant avec le VIH*
RDTs	Rapid Diagnostic Tests
RH	Reproductive Health
RPDQA	Routine Participatory Data Quality Assessment
ROADS II	Roads to a Healthy Future
SAPR	Semi Annual Progress Report
SARA	Services Availability and Readiness Assessment
SDPs	Service Delivery Points
SBC	Strategic Behavior Change
SBCC	Social and Behavior Change Communication
SCM	Supply Chain Management
SCMS	Supply Chain Management System
SDA	Small Doable Action
SGBV	Sexual Gender Based Violence
SIAPS	System for Improved Access to Pharmaceuticals and Services
SIMS	Site Improvement through Monitoring System
SLT	Senior Leadership Team
SMS	Short Message Service
SOP	Standard Operating Procedures
SP	Sulfadoxine/Pyrimethamine
STA	Senior Technical Advisor
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
SWAA	Society for Women against AIDS in Africa
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TOR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
URC	University Research Corporation
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WP	Work Plan
Y2, Y3	Project Year 2, Year 3

Introduction

The *Integrated Health Project in Burundi* (IHPB) is a five-year project (December 23, 2013 to December 22, 2018) funded by the United States Agency for International Development (USAID). IHPB builds on USAID's legacy of support to the health sector in Burundi and FHI 360 and Pathfinder's successes in assisting the Government of Burundi (GOB) to expand and integrate essential services for: HIV/AIDS; maternal, neonatal and child health (MNCH); malaria; family planning (FP) and reproductive health (RH).

The Ministry of Public Health and Fight against AIDS (MPHFA) is a major partner that is involved at every step throughout the project planning and implementation. IHPB's goal is to assist the GOB, communities, and civil society organizations (CSOs) to improve the health status of populations in 12 health districts located in the provinces of Karusi, Kayanza, Kirundo and Muyinga. IHPB's expected results are:

1) Increased positive behaviors at the individual and household levels;
2) Increased use of quality integrated health and support services; and
3) Strengthened health system and civil society capacity.

This annual report details IHPB activities, achievements and lessons learned during the period October 1, 2015 to September 30, 2016 (Y3). The project's third year represents the "high water mark" of program activities as the project moved fully from the preparatory phase to full project implementation. Despite challenges in the social and political environment, with regards to reaching its Year 3 targets as noted in the progress and discussion offered at the end of each Sub-CLIN and as summarized in Annex VI, the project made strong progress in each of its target sectors and greatly benefited from the investment made in the surveys of Year 1.

The achievements registered in Y3 can be attributed to the excellent working relationship with the central and peripheral levels of the Ministry of Public Health and the Fight against AIDS (MPHFA) and the strong support IHPB received from the various technical programs – the National Reproductive Health Program (PNSR), National Integrated Malaria Control Program (PNILP), and Department of Health, Hygiene and Sanitation Promotion (DPSHA). Highlights of activities and achievements are presented below:

- Completed a broad range of SBCC products, tools, materials and trainings;
- Developed a job aid for good drug dispensation practices and distributed it to 181 facilities (9 hospitals, 170 health centers and 2 civil society organization facilities);
- In addition to regularly providing needed kits to community health workers (CHWs) in four community case management of malaria (CCM of malaria) health districts (HDs), IHPB trained 432 (230 females and 202 males) CHWs from Gashoho and Gahombo HDs in dispensation, storage, distribution, monitoring and reporting of health commodities at the community level;
- Using gender materials developed by USAID and FHI 360, IHPB trained 14 IHPB staff (12 males and 2 females) on gender integrated approaches and 45 health workers (20 females and 25 males) on gender integrated approaches;
- With the objective to strengthen the capacity of health care providers in the clinical management of SGBV and provide an overview of psychosocial and legal aspect for the comprehensive package of services a survivor must receive, IHPB trained 107 health workers (35 females and 72 males) from across the four IHPB provinces;

- Given the quasi absence of community health information system, with the objective to capture CHW activities (home visits, home births, referrals, etc.), IHPB designed an Excel data base which was validated and started using by health district health information managers;
- Following a 4-day training of trainers on care of malnourished children at the community level for 19 health workers (5 females and 14 males), 387 CHWs (212 males and 175 females) from Vumbi HD were trained on community management of acute malnutrition including infant young child feeding (IYCF);
- Developed a simplified pictorial booklet on the seven key practices for the community component of the integrated management of childhood illness (c-IMCI) and distributed to 1,801 CHWs in Karusi and Kayanza provinces;
- Following the training of 40 trainers (38 males and 2 females), IHPB trained 527 CHWs (239 females and 288 males) on c-IMCI;
- Established a network of 24 coaches (2 district supervisors per health district) to support the facility-based quality improvement (QI) teams to achieve their integration objectives through the testing and implementation of changes in service delivery through the Improvement Collaborative Model, where QI teams meet regularly during "learning sessions" to share results of their work and identify changes that led to better integration of services;
- Continuously updated the IHPB training database – in Y3, a total of 54 trainings were conducted during 88 different sessions, resulting in a total of 2,858 individual learning sessions;
- Developed tools to collect data and aid in post-training assessment. Also, initiated the development of an integrated instrument for assessment, improvement and capacity building of FOSAs – ultimate goal is to integrate this tool in the work of district supervisors, using Open Data Kit (ODK) for deployment on handheld tablet devices;
- In addition to distributing current national guidelines and other related documents and supporting district-led quarterly meetings, in partnership with the MPHFA's Department of Planning, IHPB organized and conducted four five-day comprehensive training sessions on district planning, monitoring and evaluation of activities including health information systems – total of 112 (95 males and 17 females) staff from the four IHPB provinces were trained;
- Undertook activities to improve data quality, data demand and use at the community, facility and district levels including submission of PEPFAR quarterly report through DATIM;
- Completed and submitted the Local Partner Transition Report which presents the progress made by 3 CSOs (ANSS, RBP+ and SWAA Burundi) during two years of IHPB technical and financial support. IHPB estimated that the 3 CSOs were sufficiently strengthened technically and organizationally and are able to manage direct funding from USAID or other donors.
- Trained different categories of health workers on various services related to maternal, neonatal, reproductive and child health: essential obstetrics and newborn care (30: 11 males and 4 females); active monitoring of the third stage of labor (61: 36 males and 26 female)s; training of trainers on essential obstetric and neonatal care (15: 14 males and 1 female); clinical integrated management of childhood illness (88: 55 males and 23 females); and malnutrition management (61: 33 males and 28 females);
- Accelerated implementation of HIV/AIDS activities by identifying 107 potential HIV infection hotspots, organizing 349 outreach HIV testing and counseling (HTC) sessions, establishing 25 SRT sites followed by 56 mentoring visits, and transport of viral load and dried blood spot (DBS) spot samples;

- Key malaria achievements include: (a) Trained 195 health workers (123 males and 72 females) on new guidelines on malaria case management; trained 30 health workers as trainers (25 males and 5 females) on integrated community case management (iCCM) followed by training 286 CHWs (132 males and 154 females) on community case management (CCM) of malaria; developed and distributed 3,309 leaflets in Kirundi on the importance of preventing malaria during pregnancy;
- Developed study protocol, sought and obtained approval by FHI 360's Protection of Human Subjects Committee and Burundi Ethics Committee to conduct pilot study on integration of prevention of mother-to-child transmission (PMTCT) and Early Infant Diagnosis (EID) – study will start in Y4;
- Began systematic identification and prioritization of learning opportunities and produced four issues of the "IHPB News" and published 10 success stories;
- Fostered collaboration and coordination with USG-funded projects and organizations (MEASURE Evaluation, Burundians Responding Against Violence and Inequality, Management Sciences for Health); and
- Within the framework of IHPB staff capacity building, (a) The Child Health Specialist, who is also the Community Systems Strengthening Specialist, attended a two-week (July 18 to August 2, 2016) Summer Institute at Pathfinder International (SIP) the theme of which was "***Strengthening Community Heath Programs - Diagnosing Difficulties and Sharing Successes***" (b) The Field Office Manager for Kirundo Province participated in the 2016 Global Technical Workshop on HIV Prevention, Care and Treatment & Orphans and Vulnerable Children (September 5-7, 2016, Lusaka, Zambia) organized by FHI 360 that brought together technical staff from across FHI 360 projects and countries to share knowledge and experiences, and keep up-to-date with state of the art and international guidelines for HIV differentiated care.

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels

Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household and community levels

Planned for Year 3	Achievements and results	Comments
Establish SBCC Stakeholder Working Group		
Develop Working Group Scope of Work (SOW)	Achieved	SOW available
Convene at least four working group (WG) sessions	Partially achieved	Two WG sessions organized for Life stage I, II and III materials
Provide Working Group draft IHPB Social and Behavior Change Communication (SBCC) messages and materials, solicit feedback and incorporate	Achieved	Feedback incorporated and final materials ready
Develop campaign and materials using Life Stage Approach		
Identify graphic designer for Life Stage materials to be developed	Achieved	Two graphic designers recruited and completed development of materials
Finalize and print Life Stage I materials	Achieved	Life stage I materials printed
Plan, prepare and conduct Action Media Workshops on Life Stage II	Achieved	Action media report available
Produce first draft of SBCC materials for Life Stage II & III	Achieved	Materials developed
Pre-test Life Stage II &III materials	Achieved	Pretest report available
Finalize and print Life Stage II &III materials	Achieved	Materials developed
Strengthen MPHFA Capacity in SBCC		
Develop Burundi-specific French version of SBCC C-Module curriculum	Achieved	Module available
Convene three-day C-Module session with MPHFA staff	Achieved	18 MPHFA staff trained over a 6-day course
Community mobilization		
Develop Community Mobilization Guide	Achieved	Community Mobilization Guide available
Train 65 HPTs on community mobilization	Achieved	61 HPT trained
Meet with local leaders and community actors in each of 12 districts to monitor and support implementation of action plans	In progress	Subsequent to work plans developed by CHW
Develop and air radio serial drama that reinforces IPC and community mobilization efforts		
Advertise for and secure radio drama production house	Achieved	PCI Media Impact recruited
Develop a creative brief for radio drama	Achieved	1 creative brief produced
Draft design document and story boards	Achieved	Design document and story board developed
Draft script and storyboard for pilot episode on importance of delivery at health facility and early ANC seeking	Achieved	Detailed script available
Record and pre-test pilot episode	In progress	Planned for October
Analyze and incorporate pre-test results		Planned for October
Develop episodes 1-6		Planned for November
Produce, edit and broadcast Episodes 1-6		Planned for November

During Y3, IHPB, in partnership with DPSHA, IHPB completed a broad range of SBCC products, tools, materials and trainings. Key Y3 achievements and activities are as follows:

Establish an SBCC Stakeholder Working Group

IHPB developed a scope of work for the Technical Working Group to provide inputs to the SBCC materials and activities. The scope of work along with the request for putting in place the working group was submitted to the MPHFA. The technical working group is a formal and consultative group which brings together the Project and partners' expertise for technical and artistic analysis of all communication materials to be developed by IHPB. The SBCC Technical Working Group has the following tasks:

- Provide comments/inputs on technical and artistic quality of all developed communication materials for the four life stages (pregnant women, adolescents, young adults and parents/caregivers of children under five years);
- Coordinate communication activities across partners and organizations engaged in SBCC and health promotion work;
- Function as a clearinghouse for SBCC material for use across the country;
- Provide comments on the design document of the serial radio drama;
- Share experience and lessons learned so as to improve the state of the art in SBCC at country level and
- Contribute to the dissemination of knowledge and best practices

The Technical Working Group was set up by the MPHFA and is composed of 15 members (IHPB, MPHFA, USAID, Population Services International, Population Media Center, and 4 Provincial Coordinators of Health Promotion). The member organizations have been chosen for their expertise and roles in health communication. The technical working group has now held two sessions and reviewed materials developed for three life stages (pregnant women, young adults and adolescents).

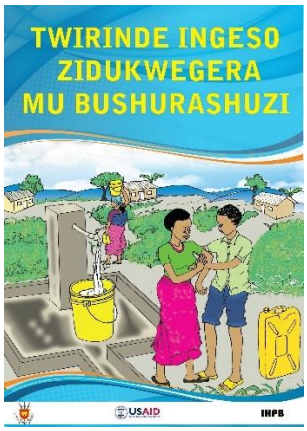
Develop campaign and materials using Life Stage Approach

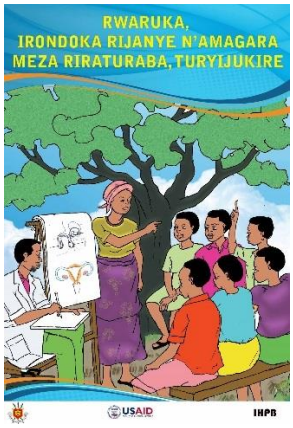
In an effort to accelerate the development of life stage-based materials; the Project identified two communication consultants to develop communication materials on pregnant women, adolescents, young adults using Life stage approach audience segmentation. The project also recruited two graphic designers who translated the work of consultants into artistic work.

Under supervision and guidance of the SBCC team, the consultants participated in all processes (from action media workshops through pretest and inputs incorporation from Working Group members. So far 21 communication materials including flip charts, booklets, leaflets and posters for the pregnant women, young adults and adolescents have been developed.

IHPB developed a leaflet, a booklet, posters and flipchart targeting pregnant women, encouraging them to seek early ANC services, danger signs during pregnancy, establish a delivery plan, and promoting exclusive breastfeeding and post-partum services. They also highlight the importance of male involvement during pregnancy. All along the development process, IHPB organized a-3-day-session of focus group discussions with 21 pregnant women and 4 of their partners to pretest the materials in Muyinga Province from 2nd to 4th February, 2016.

Pretest is an important aspect of Communication tools creation. The process helped to identify the appropriateness of the tools for the audience by assessing acceptability, attractiveness, call to action, understanding and involvement. Data were collected through focus groups with pregnant women and their male partners. The materials are now being printed and are intended to be distributed early next fiscal year.





The three sets of materials have been pre-tested with their respective target audiences - series of three focus group discussions of 10 to 14 participants were organized in Kirundo and two focus group discussions with 14 participants were organized in Kayanza provinces so that target audience members could provide feedback across five key SBCC areas: comprehension of the material's message; attractiveness of the illustrations; acceptance of the messages by the target audience; involvement; and whether the material/activity induces action. After the consultation, modifications were made to meet expectations, appropriateness, and ownership of the materials. The materials were also reviewed in terms of technical content and presentation by members of the SBCC Stakeholders Working Group. During the course of this year, the SBCC team conducted a participatory action media workshop (15-19 February 2016) with 15 young adults aged 19-30 in Kayanza to collect data on the appropriateness of the materials and messages with the target audience.

On 29 February through 4 March, the SBCC team organized a similar participatory action media workshop with 15 adolescents aged 15-18 in the province of Kirundo. The main objective of this consultation process was to gather feedback on illustrations and messages in order to finalize the communication materials for this audience. The two workshops enabled field facilitators to gather input on barriers and messaging on HIV/AIDS prevention and testing, the delay of sexual debut, sexual and reproductive health information seeking from trusted sources, and condom use and male circumcision.

Key messages for pregnant women are on intermittent preventive treatment of malaria during pregnancy (IPTp), antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, long-lasting insecticide treated net (LLIN) use, reduction of exhaustive work, birth preparedness and delivery at a health facility, danger signs of pregnancy.

The key messages for young adults are based on sexual and reproductive health (SRH), HIV/AIDS prevention and testing, delay sexual debut, sexual and reproductive health information seeking from trusted sources, and condom use and male circumcision.

Strengthen MPHFA capacity in SBCC

In year 3 of Project implementation, IHPB adapted the C-Module and with the help of a consultant, contextualized it for Burundi. The module consists of six sections: Introduction of SBCC fundamentals, analysis of the situation, designing a strategy, messaging and materials creation, implementing and monitoring as well as evaluating and planning. The C-Module was used as training material for 18 MPHFA (PNILP, PNLS, PNSR, PEV, DPSHA and 4 provincial DPSHA staff) and CSO staff (SWAA Burundi, ANSS and RPB+). The theoretical and practical training was held in Kayanza Province and took six days.

To contribute to the MPHFA's ability to implement SBCC at the community level, IHPB hired an external consultant to finalize the SBCC training curriculum module that was in a draft form; the consultant also completed preparations for an SBCC training workshop. The modification aimed to achieve an appropriate balance between the material presented in the C-Change modules and practical field session.

The SBCC training module helps trainees to: practice undertaking a root cause analysis using existing data from Demographic and Health Survey Burundi; identify a small doable action that can be carried out by the community, and conduct an "Action Inquiry," in focus groups with the community to narrow down the lists of small doable actions, and conduct role play that will help practitioners to negotiate the identified small do able action with the community.

Community mobilization

IHPB developed a Community Mobilization Guide which provides Health Promotion Technicians with mobilization strategies and techniques on how to identify public health problems and develop appropriate strategies to address them. Through practical exercises the health promotion technicians (HPTs) identified small doable actions in the community. The guide was used during two-day-training that targeted 61 health promotion technicians from the 12 IHPB districts.

The Community Mobilization Guide has been subject of practical inputs as suggested by the SBCC Consultant with more focus on small doable actions. For this end, SBCC team organized two separate two days training for Health promotion technicians into 2 sessions. In total, 61Trainees (7 Females and 54 males) originated from the 12 Health districts participated. The training focused on strengthening their skills in community mobilization. Basic of behavior determinants, the use of various communication mix to better reach the audience, steps to conduct any community mobilization activities and practical session on work planning

Develop and air radio serial drama that reinforces interpersonal communication (IPC) and community mobilization efforts

Following an open tender process, IHBP retained the services of Population Communications International (PCI) Media Impact to produce and disseminate a serial radio drama to reinforce community health mobilization efforts described above. A contract has been signed with FHI360. PCI Media Impact has identified a national production house (Rockhouse Production) that has helped to recruit local actors and facilitate setting the local production equipment that will help for recording. A Design document have been developed and clearly show an expanded outline of the radio programming with dedicated time allocated to the drama followed by dialogue between listeners and the host and/or listeners.

The character's profiles were developed and describe a CHW and local leader as positive characters, a shop holder and two farmers as transitional characters and a farmer, TBA and an unemployed as negative characters. The storyline has also been developed for the 6 episodes focusing on key actions to promote the importance of seeking early (first trimester) antenatal care to pregnant women and planning for an assisted-delivery in a facility, identifying danger signs of pregnancy, advocating for reducing exhausting work and avoiding lifting heavy objects and promoting LLIN use. The first two episodes have been developed and are ready for pretest.

In addition to the aforementioned activities planned for Y3, IHPB conducted awareness raising activities through mobile cinema in the Gashoho Health District to promote healthy community behaviors and the uptake of health services for improved maternal, neonatal, and child health. Messages focused on: the importance of seeking early (first trimester) antenatal care and planning for an assisted-delivery in a facility; long lasting insecticide treated net use and exclusive breastfeeding for six months.

The mobile cinema reached an estimated 1,265 people (1,080 females and 185 males) at six sites (Nyungu, Gashoho, Kiremba Gisanze, Bwasare, and Kizi). This activity is entertaining for community members and creates a platform to discuss ways to address barriers to adopting these healthy behaviors and seeking care at the facility.

Progress and discussion on the SBCC results indicators

Indicator	**Target FY2016**	**Achieved to date FY 2016**				
		Oct-Dec 2015	Jan-March 2016	April - June 2016	July - Sept 2016	Total
1.0.1. Percent of the targeted audiences who report practicing positive behaviors at the individual and household levels [Mandatory Result]	N/A	The Outcomes indicators will be measured through the end of project survey, planned in Y5				
1.1.1Percent of the targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels [Mandatory Result]	N/A					
1.1.2. Percent of targeted population who correctly report causes of specific illness (e.g. HIV/AIDS; malaria; diarrhea) [Mandatory Result]	N/A					
1.1.3. Percent of the target population who recall hearing or seeing or reading a specific HC message	N/A					
1.1.4 Number of health communication materials developed, field tested, and disseminated for use	4	1	10	10	0	21

1.1.4. Number of health communication materials developed, field tested and disseminated

The target for this Fiscal Year 2016 is 4 communication materials, IHPB strategized to hire additional consultant to help in the development of communication materials to accelerate community activities

with CHW's resulting in the development of 21 materials. Three sets of communication materials for pregnant women, adolescents and young adults have been developed. They include posters, flipcharts, booklets and leaflets. The number of communication tools developed and field tested has reached 21 but yet to be disseminated.

Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and household

Planned for Year 3 activities	Achievement and results	Comments
Construct supply chain process map and monitor stock-outs	Not achieved	IHPB submitted a request for an identified local consultant to conduct a SCMS analysis in IHPB provinces. USAID COR did not approve because of concerns that activity might be a duplication since USAID has other mechanisms to support SCM assessment in Burundi
Convene three four-day training sessions on SCM for pharmacy staff from Gahombo, Kayanza, Musema, Gashoho, Giteranyi and Muyinga districts	Achieved	103 pharmacy staff trained from Kayanza , Gahombo, Musema, Gashoho , Giteranyi and Muyinga health districts
Develop and distribute job aid for good dispensation practice to district hospitals and health centers	Achieved	Job aid developed and distributed to 181 facilities
Conduct quarterly SCM supervision visits for Kirundo, Mukenke, and Busoni health districts	Achieved	Supervision visits conducted in Kirundo, Mukenke, Busoni and Vumbi health districts
13 two-day SCM training sessions convened for CHWs in Gashoho and Gahombo health districts	Achieved	Instead of 13 two-day sessions, 8 two-day training sessions were organized. As was planned, all 402 CHWs were trained - Gashoho (160 CHWs) and Gahombo (242 CHWs).
Provide essential tools and supplies to support CHWs in CCM focus areas	Achieved	Appropriate quantities of gloves for use by CHWs in Gashoho, Musema ,Gahombo and Kirundo Health districts were delivered
Avail project vehicles (on a need basis) for timely delivery of commodities to health facilities per districts' requests	Achieved	For the transport of commodities and test samples, IHPB availed vehicles ten times every month

In Y1-2 IHPB examined facility and district health system capacity and performance in SCM through the analysis of data from the Service Availability and Readiness (SARA), facility quality Assessment (FQA) and BDS assessments. Results helped identify bottlenecks at facility, community and district levels and performance gaps and barriers (power quantification, inadequate transportation) in the supply chain that are the main causes of stock-outs of essential medicine and commodities.

In Y3, IHPB's SCM work focused on promoting uninterrupted supply of HIV and STI-related commodities, as well as neonatal, child health, family planning, and malaria supplies, from central warehouses to facilities and community health workers.

Y3 SCM achievements include the following:

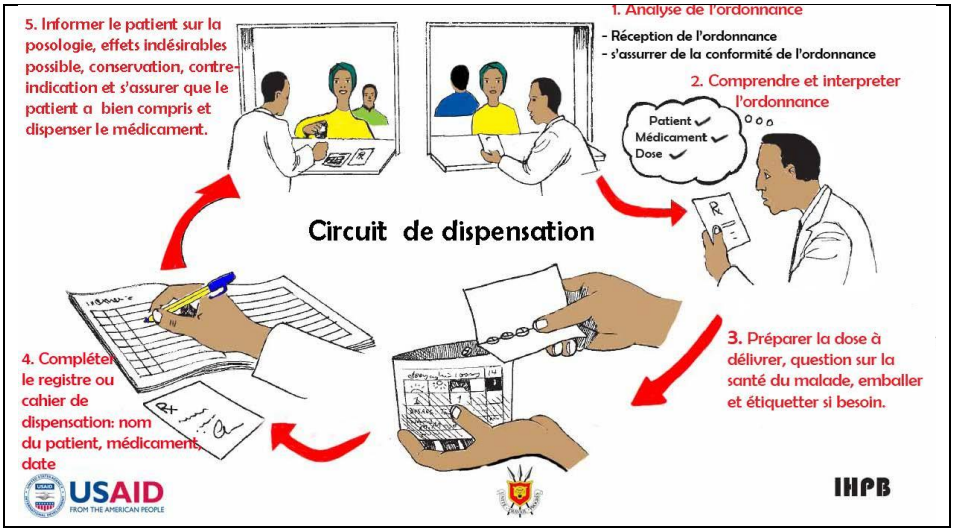
Construct supply chain process map and monitor stock-outs

During Year 3 activity, IHPB was preparing for the start of a local SCM consultancy, although it was not approved by USAID due to the timing of the work and concerns of duplicated efforts; until the end of September 2016, SCM activities in Burundi are supported by MSH's SIAPS and starting in October 2016, by a new Procurement Supply Management (PSM) Project by Chemonics.

As such, in Y3 the project worked to compile the general trends and underlying causes of SCM bottlenecks as observed at the district, facility, and community levels. These trends and underlying causes will be included in the project's facility-level integrated instrument being developed so that specific facilities' SCM challenges can be better assessed, documented, analyzed and communicated to appropriate stakeholders for their consideration and action.

Develop and distribute job aid for good dispensation practice to district hospitals and health centers

A job aid for good drug dispensation practice was developed in Y3 (shown below) and distributed to pharmacies in 181 health facilities (9 hospitals, 170 government health centers and two CSO health centers) across all four project provinces (Kayanza, Karusi, Kirundo and Muyinga).



Conduct quarterly SCM supervision visits for health districts

IHPB in collaboration with districts health bureaus organized routine supervision visits in Kirundo, Busoni, Mukenke and Vumbi health districts. These supervision visits aimed at reducing stock-outs by improving the calculation of Average Monthly consumption of inputs based on their stock cards, improving filling and record-keeping of management tools and sharing best practices in distribution.

Prior to the training sessions, some pharmacies were managed by the heads of health centers (*titulaires*). However, the MPHFA Ordinance of MPHFA stipulates that health centers' pharmacies should be managed by health centers' deputy managers (*titulaires adjoints)*. Thus, the project worked to conduct trainings with the appropriate staff, so that after the trainings the management responsibility was transferred to the deputy heads of pharmacies

3 Sessions of 4-day training in supply chain management for SCM pharmacy staff in Muyinga and Kayanza health provinces

IHPB collaborated with health district offices to conduct two 4-day training sessions for 106 pharmacy staff who are also health facility deputy managers (73 females and 33 males) from Kayanza, Gahombo, Musema, Gashoho, Giteranyi and Muyinga health districts. The training organized using sections of MPHFA's Management Tools and logistics of pharmaceuticals, February 2015.

2-day training sessions on supply Chain Management for Community health workers in Gashoho and Gahombo health districts:

Instead of 13 sessions, IHPB conducted 8 sessions of 2-day trainings in collaboration with Gashoho and Gahombo Health Districts for Community Health Workers. A total of 432 CHWs (230 females and 202 males) were trained by health promotion technicians (HPT). This training was aimed to reduce stock-outs by improving the calculation of Average Monthly consumption of inputs based on their stock cards, improved filling and keeping management tools, filling tools, and best practices in distribution.

Provide Kits to CHWs for the Community Case Management of Malaria (PECADOM) in intervention areas:

During the reporting period, in addition to supplying (on as needed basis) necessary kits and items to CHWs in Gashoho, Gahombo and Kirundo health districts, the following items were provided to 208 CHWs in Musema - registers of cases, referral and requisition book, iCCM module, box, cadena, solar lamp, bag, jerrican, spoons, cup of 500 ml, safety box, box of 50 pairs of gloves, trash can, manual timer, algorithm and job aid for malaria care and use of rapid test diagnostics.

Avail project vehicles (on as need basis) for timely delivery of commodities to health facilities per districts' requests

IHPB supports health districts to transport drugs and consumables; specifically, the project provided a supply vehicle for the health district Gashoho to ensure the availability of commodities. In addition, the project facilitated the transport of commodities from CAMEBU (and INSP) to health districts pharmacy and DBS and Viral Load blood sample from health facilities to the National Reference Laboratory (INSP) or private laboratory which IHPB has contracted during periods of breakdown of the INSP equipment.

Progress and discussion on the SCM results indicators

Indicator	**Target FY2016**	**Achieved to date FY 2016**				
		Oct-Dec 2015	Jan-March 2016	April-June 2016	July-September 2016	**Total**
% of supported facilities that experience a stock-out at any time during the last three months [MR]	55%	64.6%	64.3%	39%	62 %%	**57.3%**
% of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptive method that the SDP is expected to provide at any time during the reporting period	20%	28.2%	4.1%	6.1%	17%	**13.6%**
% of health centers that meet minimum SCM standards	88%	N/A	N/A	N/A	N/A	**N/A**

% of supported facilities that experience a stock-out at any time during the last three months [MR]: Data is routinely collected from in GESIS and DHIS 2. The Y3 target was achieved at 95%[1]. During the first, second and fourth quarters even if we had some stock outs due to lack of products at central ware house, the target was achieved.

% of USG-assisted service delivery points (SDPs) that experience a stock out of a contraceptives method that the SDP is expected to provide at any time during the reporting period:

Data on contraceptive products collected from facility reports, showed that for the first and fourth quarters of Y3, we registered stock outs (mainly due to lack of timely requisitions by health facilities) but for the 2nd and 3rd quarter stock out are reducing and the target was achieved. With an average of 13.6%, for Y3 the target was achieved at 130%[2].

% of health centers that meet minimum SCM standards:

Data for this indicator is obtained from PBF reports. Since IHPB is not supporting PBF, data is not at its disposal. However, IHPB is looking for ways to access the PBF information in order to inform this indicator.

Sub-CLIN 1.3: Strengthened support for positive gender norms and behaviors and increased access to GBV services

Sub-CLIN 1.3.a: Strengthened support for positive gender norms and behaviors

Planned for Year 3	Achievements and results	Comments
Train IHPB and CSO partner staff on gender integrated approaches	Achieved	14 IHPB staff trained
Develop Gender Strategy	Achieved	The gender strategy is based on the results of the gender analysis
Conduct stakeholder dissemination workshop for IHPB Gender Strategy	Scheduled for Year 4	The strategy will be disseminated along with the gender analysis findings. It was agreed with MEASURE Evaluation to jointly disseminate their PEPFAR Gender Analysis findings simultaneously with IHPB in Q1 of IHPB's Year 4.
Conduct training on gender integration for district hospital health providers	Achieved	45 health providers trained
Implement gender integration activities as specified in the Gender Strategy	Ongoing	Integration activities are included in the Year 4 workplan

In Y3, IHPB implemented activities in order to address gender norms and inequalities in their relation with health. The main achievements are:

[1] The target for this indicator is negative (-10%). So, for a target of 55%, 57% is an achievement rate of 129% with following formula [1+((55%-57%)/55%)].

[2] This is a negatively formulated indicator. So, for a target of 20%, 13.6% is an achievement rate of 130% using following formula [1+((20%-13.6%)/20%)].

Train IHPB staff and CSO partner staff on gender integrated approaches

The Project organized one training for the project technical leads in order to increase their understanding of gender norms and inequalities and how they affect health outcomes, and identify opportunities to address gender themes (e.g. male norms, GBV, service equity, power imbalances within the household, etc.) across IHPB interventions and technical strategies. The training utilized gender materials developed by USAID and FHI 360. In total, 14 IHPB technical staff (including 12 men and 2 women) participated in the training.

Develop Gender Strategy

In the course of Year 3 implementation, IHPB developed a gender strategy which was guided by the gender analysis findings which identified key gender issues affecting each of IHPB's priority health areas. The IHPB Gender Strategy provides guidance on how to best integrate gender throughout IHPB activities, including through GBV prevention and response strategies and specifies how IHPB defines, monitors and measures progress and achievements in gender integration. The gender strategy was developed in collaboration with project and STTA leads across programmatic and technical areas. In the development process, the STTA provided training to staff and got their inputs to ensure the guidance for gender integration activities would be applicable to the local context.

Conduct training in gender integrated approaches for district hospital health providers:

The training was conducted in two sessions of two days each. The training targeted 45 health providers (20 women and 25 men) from the 9 IHPB partner health district hospitals. Participants were selected from the following services: pediatrics, HIV, maternity, ANC and Family Planning and health information system (SIS). The objectives were to increase understanding of gender norms and inequalities and how they affect health outcomes, and identify opportunities to address gender themes (e.g. male norms, GBV, service equity, power imbalances within the household, etc.) across IHPB interventions and technical strategies. The post-test results showed good improvement on knowledge of gender integrated approaches among the health providers. The two-day-training sessions were simultaneously conducted in Kayanza and Muyinga Provinces. The 45 health care workers are expected to initiate gender integration activities into services (example, allocate more time in services provided to women, ANC, etc.).

Implement gender integration activities as specified in the Gender Strategy:

Successful gender integration requires two components: technical and structural. Technical integration activities will address gender differences and constraints in programming during Year 4. During Year 3, IHPB focused on implementing structural integration activities which calls for gender to be addressed in the project's policies and practices in a way that is systematic and continuous. As such, the aforementioned staff trainings on gender and gender integration were conducted to build the project's institutional gender expertise so that it would not remain centralized in one department or with one gender point person. In preparation for implementing technical gender integration project all program staff must understand the gender-differentials related health. This provided guidance for Y4 planning to meet technical gender integration.

Progress and discussion on the gender results indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec	Jan-March	April-June	July-Sept	Total
Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household).	4	0	0	1	2	3

Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household): in the process of achieving this indicator, the Project conducted a series of trainings (two sessions on gender integration and 4 sessions on comprehensive SGBV case management) to first build the staff's capacities in gender integration and create a strong foundation for implementation of programmatic gender integration interventions. Those interventions are activities which address gender-related barriers in communities that impede an individual's ability to achieve optimal health. These interventions are structural and intended to raise gender awareness for staff and partners.

Sub-CLIN 1.3.b: Expand access to high quality comprehensive services for GBV survivors

Planned for Y3	Achievement and results	Comments
Coordinate and provide support for supervision of GBV clinical services	Partially achieved	53 facilities supervised.
Organize SGBV job aid validation workshop	Not achieved	Job aid was addressed to national trainers for their inputs
Train 104 health and non-health providers from the four provinces on clinical management of SGBV	Achieved	107 health providers trained
Disseminate SGBV job aid through a workshop	Planned for after validation	
Support quarterly multi-sectorial coordination meetings to discuss GBV issues	Not achieved	Only Kayanza province accepted inclusion of GBV issues in the agenda

To further expand access to clinical services for gender based violence (GBV) survivors, in Y3 IHPB implemented activities which aim to strengthen the capacity of providers within supported health facilities to deliver an essential package of GBV clinical services, including emergency contraception (EC), post-exposure prophylaxis (PEP) for HIV and other STIs, treatment of injuries, and psychosocial support. The project also continued coordinating supportive supervision visits and strengthening providers' capacity in GBV services and support at health facilities and district level. IHPB worked to ensure access to capacity building opportunities for those who have not benefited from them in the past, and foster greater sustainability in the coordination of such trainings. Key Y3 achievements include:

Coordinated and provided support for supervision of gender based violence (GBV) clinical services:
IHPB supervised GBV-related services in 53 health facilities (5 in Kayanza and 48 in Muyinga) during integrated supervisions conducted by field officers in the two provinces. In Kayanza, it was noticed that

drugs for post exposure prophylaxis (PEP) were not available. The main cause was that providers did not have PEP kit stocked. It was recommended that health facilities should have at least two kits for GBV survivor care and facilities should order PEP drugs in upcoming orders to the health district pharmacy. In Muyinga, the main challenge noticed was related to data collection tools; it was recommended that the province staff use the same tool as other provinces, where GBV data are reported in the HIV data collection sheet. The other issues identified during the supervision was the capacity of health providers to manage GBV cases and to address this, trainings were organized for providers from 5 health districts.

Organize SGBV job aid validation workshop:

The National Program of Reproductive health (PNSR) invited IHPB to a ten-day training-of-trainers session for national GBV trainers. IHPB was represented by two staff out of the twenty people trained as trainers. While this offered an opportunity for IHPB to present the SGBV algorithm to the team members who gave their inputs, the idea of a validation workshop was cancelled. It was observed during the training that there were many tools to disseminate in health facilities as Burundians Responding Against Violence and Inequality (BRAVI), a USAID funded program in Burundi implemented by Engender Health, also proposed other tools on the same topic. PNSR will coordinate a workshop to select tools to be disseminated in health facilities.

Support quarterly multi-sectorial coordination meetings:

During coordination meetings organized under IHPB support in the four provinces, there were no GBV issues discussed. The project took the opportunity to raise the GBV issue during one-day workshops on maternal and child health (MCH) organized in Kayanza for community leaders. A total of nine workshops, whose objective was to increase demand for MNH services were organized for a total of 744 participants (253 females and 391 males) attending these workshops. During these workshops community leaders were asked to sensitize community members of the importance of seeking health services within 72 hours of rape and to inform people of the availability of GBV services in health facilities.

Trained health workers on GBV case management:

In collaboration with the Muyinga health province and PNSR, IHPB conducted a five-day training session for 22 health providers (12 females and 10 males) from Muyinga using the « MANUEL DE FORMATION SUR LA PRISE EN CHARGE GLOBALE DES VICTIMES DES VIOLENCES SEXUELLES ET VIOLENCES BASEES SUR LE GENRE » (Training Manual on the Global Management of SGBV Victims) before PNSR decided to postpone all trainings on GBV, until the BRAVI manual was available in June. From July, four other six-day training sessions were organized for 85 (23 females and 62 males) providers from five health districts (Buhiga, Nyabikere, Musema, Busoni and Mukenke health districts). The objective of the training is to strengthen the capacity of health care providers in the clinical management of SGBV and provide an overview of psychosocial and legal aspect for the comprehensive package of services a survivor must receive." Guide de formation sur la prise en charge intégrée des violences sexuelles et basées sur le genre", the training manual developed by BRAVI, was used for the training. All the health facilities from the five health districts have now at least one health worker trained on GBV. As a World Bank supported (by the PNSR) province, IHPB will not be supporting GBV trainings in Muyinga province.

Progress and discussion on the GBV results indicators

Indicator	Target FY2016	Achieved for FY 2016				
		Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sept	Total
1.3.2 Number of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products	***1***					***0***
1.3.4 Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)	150	30	26	27	56	139 (93%)
1.3.5 Number of facilities that provide PEP to GBV survivors	27	23	23	23	26	26 (96%)
# of persons trained on GBV case management	104	0	22	0	85	107 (103%)

Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products

The LOP target set for this indicator is six out the 12 IHPB health districts. Given no districts were served in Y 1 and 2, the Y3 target is 1 health district and it is reported annually and it concerns GBV program and male involvement initiative. IHPB targeted Buhiga health district and started the GBV program where we conducted training for (each health facility so that they have at least one provider trained on GBV case management) and the next step will be to implement male involvement activities in the district through community mobilization activities for the first time after IHPB gender strategy is available. Note that all trainings on GBV were postponed by the PNSR until the training guide developed by BRAVI is available.

Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)

By the end of September 2016, a total of 139% survivors received post-GBV care which is 93% of the IHPB Y3 target. Considering the fact that we did not have data for September and we considered only data from 2 provinces where HIV activities are supported.

Number of facilities that provide post-exposure prophylaxis (PEP) to GBV survivors

During the FY 2016, a total of 26 health facilities reported on PEP provision to GBV survivors, which represents 96% of the Y3 target. This situation could be explained by the fact that the MPHFA reviewed its policy related to antiretroviral (ARV) treatment and all satellite sites now have autonomy to prescribe ARVs, while previously only hospitals could prescribe them.

Number of persons trained on GBV case management

By the end of September 2016, a total of 107 persons were trained, surpassing our target of 104.

CLIN 2: Increased Use of Quality Integrated Health and Support Services

Sub-CLIN 2.1: Increased access to health and support services within communities

Planned for Y 3	Achievement and results	Comments
Design community database and submit to BDSs and BPSs for adoption and use	Achieved	An excel database was designed and adopted
Support BDS quarterly visit to CHWs and COSAs in Kayanza and Muyinga	Partially Achieved	102 out of 348 planned sessions were conducted
Support the BPS to organize a semiannual coordination meeting on community health system in Kayanza and Muyinga provinces	Partially achieved	One meeting was held in each province
Conduct five-day training of 20 trainers from Kirundo and Vumbi on community component of National Protocol of Acute Malnutrition Management	Achieved	19 participants were trained as trainers
Conduct three-day training for 345 CHWs from Kirundo and Vumbi health districts on Community Management of Acute Malnutrition, including IYCF	Achieved	387 CHWs were trained
Support the HPT to conduct a quarterly visit to CHWs to coach them on malnutrition screening and management in Kirundo and Vumbi health districts	Not achieved	Inadequate number of HPTs to conduct supervision
Conduct a 3-day training of 87 members of 29 COSAs from Kirundo and Muyinga provinces on *Curriculum de Renforcement des COSAs*	Partially achieved	60 members of 20 COSAs were trained
Organize supervision visit to 49 COSAs	Partially achieved	24 COSAs were supervised

In Burundi, health-related services are provided at community level by different actors; however, the MPHFA only formally recognizes CHW and COSAs in this role. IHPB committed to strengthen these two categories of community health actors. During year 3, the following activities were conducted:

Design a community data base and submit it to the BDS and BPS for adoption and use

In year 2, IHPB supported two coordination meetings on community health system in Kayanza and Muyinga provinces; it was noted, among other challenges, the quasi absence of a real community health information system; the health district was missing a bank of community-based data. IHPB committed to put in place a community database at district and province level, the following year. An Excel database was therefore designed, including all the categories of CHW activities: home visit, mass sensitization meetings, curative activities, referral, community-based events such as home-birth, etc. The database was debated and validated during the coordination meeting and was handed over to health information system managers at health district for use.

Support BDS quarterly visit to CHWs and COSAs in Kayanza and Muyinga provinces

Meetings were held by health district offices in health centers of Kayanza and Muyinga provinces involving CHWs, health care providers, the health promotion technician (HPT), and the president of COSA. These meetings aimed to strengthen the link between the community health system and the health centers. Community health data were analyzed using CHWs monthly reports; several weaknesses and errors were noted and corrected. The errors noted are: the number of households in the health center's catchment area is discordant in the different sections of the reports; discordance between

severe acute malnutrition cases and the number of referrals for malnutrition in under five children; the sum of number of children screened for malnutrition in each category (red, yellow, or green color on MUAC and edema) is different from the total number of children screened. However, the CHWs monthly reports provide information for decision making: a large number of households do not have adequate latrines, some health centers have a large number of home births, some households have no mosquito nets. While it was planned four visits for each of the 87 health centers of Kayanza and Muyinga provinces, totalizing 348 visits, 102 visits were achieved. In fact, the unavailability of district staff made difficult to conduct the planned visits to health center, obliging us to shift the activity from health center and organize it at commune level where we could gather several health centers at the same time. The large number of CHWs makes it impossible for the health system to visit them quarterly.

Support the BPS to organize a semiannual coordination meeting on community health system in Kayanza and Muyinga provinces

Coordination meetings on community-based activities were held in Muyinga and Kayanza provinces, involving health care providers from health centers, health promotion technicians, supervisors from the BDS and BPS, responsible of health information system in BDS and BPS, the medical responsible of health district, and the province health office chief.

The following points were debated: follow up recommendations of the previous meeting; harmonize community data collection tools; determine the community reporting circuit; discuss on the community database suggested by IHPB; the collaboration between the health centers managers and the health promotion technicians; and how to improve the quality of CHWs supervision.

The main results are, among others: health centers heads understood the attributions of the HPTs and ceased to assign them to fill in the reception books; some health centers heads provided CHWs with working note-books; health centers heads and HPTs improved their collaboration, the HPTs submitting their plan of field visits, and the health centers heads accepting to facilitate transportation. However, the suggestion consisting in assigning one health care provider to community coordination in the health centers without a health promotion technician to fill the gap in CHWs supervision was judged impossible because of the shortage in health care providers.

Conduct training of 20 trainers from Kirundo and Vumbi on community component of National Protocol of Acute Malnutrition Management

IHPB supported a 4-day training of trainers of CHWs on the care of acute malnutrition at community level; the training was organized by the health district office with the technical assistance of the central level of the MPHFA. From Vumbi health district 19 participants, 5 females and 14 males, were trained as trainers of CHWs including 13 health centers heads, 3 HPTs, and 3 supervisors of district. Trainers were the medical chief of district Vumbi, the medical chief of province, the health promotion coordinator at province level, 2 persons from the central level of the MPHFA, and the child health specialist at IHPB. The aim of the training was to build capacity of the participants and make them capable to transfer the skills to CHWs to implement community-based management of acute malnutrition including screening, referral, and education. Themes debated included: nutrition concepts definition, cycle infection-malnutrition, causes and consequences of malnutrition, the 7 key behavioral practices to improve child health including exclusive breastfeeding, complementary feeding, hand washing, diarrhea management, and health care seeking, and the standard CHWs report. The training

began with a pretest and ended with a posttest with as results an average of 73.6% in the score in the pretest (61% to 89%); and an average of 87% in the post test (75% to 97%).

Conduct three-day training for 387 CHWs from Vumbi health district on Community Management of Acute Malnutrition, including IYCF

In collaboration with Vumbi health district and Kirundo province health office, IHPB supported in two sessions, a 3-day training for 387 CHWs from Vumbi health district on the management of acute malnutrition at community level, including screening, referral, and education on the seven key messages on child health. This training was facilitated by 19 trainers including 3 supervisors of district, 3 health promotion technicians, and 13 HC-based care providers who had been trained as trainers. The medical chief of district, the medical chief of province, the health promotion coordinator at province level, and one person from the central level of MPHFA supervised the activity. The training began with a pre-test and ended with the post-test with a score average of 38% in the pre-test (4% to 74%), and 79% in the post-test (28% to 100%). The modules included: malnutrition screening, malnutrition management protocol, referral, and education on the 7 key behavioral practices in child health.

Observation: while policy indicates that a CHW must have a primary school level of education, some CHWs are illiterate. A suggestion has been addressed to the medical chief of district to replace CHWs who are not writing well.

Conduct a 3-day training of COGES/COSA members from Kirundo and Muyinga provinces on the health center management

Two 3-day training sessions were organized for 60 members (22 females and 38 males) of 20 COSAs (3 members per COSA) in Kirundo and Muyinga provinces on the management of the health center. The training targeted the COGES[3] sub-committee members and aimed to strengthen COSAs to make them capable to induce a good management of health centers and targeted COSAs that did not meet all the functionality criteria according to SARA. The subject included: COSAs history; COSAs organization; COSA role and responsibilities; barriers to health care access; health center technical management; HC financial and stock management; performance indicators matrix for COSA. The training began with a pretest marked by an average of 44%, the score varying between 0% and 90%; while the posttest had an average of 65%, the score varying from 35% to 97.5%. Some big challenges were noted such as: Some COSA members do not meet the required profile: while the *Manuel des Procédures en Santé communautaire* states that a COGES member has at least the national lowest diploma, some of them are illiterate; COSA members are not renewed according to the policy.

Organize supervision visit to COSAs

In collaboration with the health district bureaus, IHPB conducted a supervision visit in 24 COSAs whose COGES members were trained on the management of health center in Kayanza and Kirundo provinces. The activity aimed to assess the added value of the training, and reinforce the COSA's functionality by training COSA members on their scope of work. The CPPS, the health district administrator, and the supervisors participated to the activity. The methodology adopted was: gathering all COSA members in one room at the health center, asking the COGES members the added value of the training they had,

[3] COGES is a sub-committee of COSA comprising 3 members with a relatively high education level that works closely with the health center managers in health center management.

and engaging discussion between COSA's members on the COSA's organization, role and responsibility, explaining the history and the purpose of COSA. COSAs members were given the opportunity to ask questions, do comments, and express their complaints. At last, discussion was conducted with the health center's head on the activities of the COSA, and he was provided with a copy of the *Manuel des procédures en santé communautaire* that describes the attributions of all the community health actors. The points evoked by COGES members as the added value of the training are such: collaboration between COGES/COSA members and health centers managers improved; COGES/COSA members are more involved in financial and personnel management; COSA members participate in health center-based personnel conflict resolution; COSA is now actually involved in planning, instead of being merely informed; COSA has its own work plan different from the health center's one.

In addition to planned activities, IHPB carried out the following activities:

Training CHWs on community component of IMCI in Nyabikere and Buhiga health districts

IHPB supported the health districts to conduct a 5-day training of 527 CHWs from Nyabikere and Buhiga health districts (239 females and 288 males) on the community component of IMCI. The community component IMCI consists in a package of 7 key behavioral practices that could improve child health: early and exclusive breastfeeding, complementary feeding, hand washing, diarrhea management, malaria prevention, danger signs recognition and health services seeking, and immunization. The training of CHWs, preceded by a training of 40 trainers including health promotion technicians, health center-based care providers and supervisors of BDS, was organized at commune level. CHWs were divided into 30-trainee classes each one with 3 trainers. The health district and the province health offices supervised the activity. This training helped to expand the area where IHPB collects data for the mandatory indicator "number of women reached by the education on exclusive breastfeeding".

Designed, for CHWs, a simplified booklet on the 7 key messages of child health

A simplified booklet on the 7 key practices of community component of the integrated management of childhood illnesses (IMCI) was designed in collaboration with the MPHFA, tested with CHWs, health promotion technicians, and health center-based care providers, and made available for use. In effect, the government of Burundi adopted IMCI approach to treat and prevent illnesses that kill the most children. The community component of the strategy comprises 19 practices to be adopted by families and community; 7 of the 19 practices were taken as key practices, and are subject to CHWs training and work. The booklet was worthwhile because CHWs didn't have any simplified document on the 7 key practices; they used a comprehensive guide comprising the 19 practices, without illustration, not easy to use. The booklet was used in training CHWs and was distributed to 1801 CHWs from Karusi and Kayanza provinces, and Vumbi health district.

Held mentoring meetings of CHWs on community-based management of acute malnutrition in Nyabikere health district

In collaboration with Nyabikere health district office, IHPB organized meetings with CHWs from Nyabikere health district, to coach them on the management of acute malnutrition at community level. These CHWs had been trained at the end of the previous fiscal year in September 2015 on the management of the acute malnutrition including screening, referral, and education. The meetings, held at commune level, included all the 186 CHWs, 18 health centers chiefs, and 7 health promotion technicians; and embraced community data analysis; a reminder on the protocol including malnutrition

screening, the referral system including referral and counter-referral from the health care providers to the CHWs, and the nutritional education; and a reminder on the report form filling.

The main issues identified are: (a) only two health centers are accredited with services for all categories of malnutrition (severe and moderate malnutrition). (b) Some cases of malnutrition (even cases of severe malnutrition) are referred but refuse to go to the health facility, or the health facilities have no material (therapeutic foods); CHWs are therefore obliged to help the caregivers of these children to rehabilitate them using the locally produced foods.

Table below indicates the number of cases screened and cases referred during the period October 2015 – August 2016

	Number	**Referred cases**
Number of children screened for malnutrition	76,010	
Number of children who were in green color with MUAC (without malnutrition)	70,825 (93.2%)	-
Number of children who were in green yellow with MUAC (moderate malnutrition)	4,644 (6%)	3,311
Number of children who were in green red with MUAC (severe malnutrition)	1,093 (1.4%)	1,087
Number of children with edema (severe malnutrition)	444 (0.6%)	419

Introduce the immunization surveillance by CHWs using note-books

An integrated supervision conducted in maternal and child health conducted in Karusi province revealed the absence of a follow-up system for cases of immunization drop out; it was therefore decided to use CHWs in the immunization surveillance. CHWs were provided with note-books to use in following up pregnant women and children immunization. They benefitted from a one-day training on the use of the note-books, dividing it for the different area of their activities. For immunization surveillance, it was suggested a table where they will be recorded all the children aged of less than 2 years and the dates the different vaccines are scheduled; the CHWs will follow up by checking if every child received all the scheduled vaccines, if not, the child will be immediately referred to the health center.

Progress and discussion on the community system strengthening indicators

Indicator	**Target FY 2016**	**Achieved**
Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services	5%	36.1%
Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)	62,000	139,663
Percent of health facilities that have functional CHW systems	16%	Data not yet available
Percent of COSAs that meet defined functionality standards	72.7%	61.1%

Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services

Data are obtained from facility-based survey conducted through interviews with health promotion technicians. The baseline for this indicator was 0% because CHWs had a non-harmonized capacity in that some of them had been trained on a particular service and not on the others. The 2016 target was

5%; the achievement is 36.1% due to the fact that many training sessions for CHWs were conducted on different subjects completing package of activities they provide.

Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)

The data are extracted from the CHWs monthly reports they transmit to the health centers in iCCM strategy, and from the health center to the health district office. The 2016 target was 62,000; the achievement is 139,663 representing 225% of the target. This is due to the fact that the area where iCCM is implemented was extended from three health districts (Kirundo, Gashoho, and Gahombo) to four health districts (Musema health district was added in May 2016). In addition, due to the malaria outbreak that affected the IHPB-target provinces from January to March 2016 increased sensibly the numbers of cases.

Percent of health facilities that have functional CHW systems

The health centers with CHW systems that meet functionality standards are defined as health centers that score 50/50 on indicator 17 of the PBF Health Center Technical Quality Assessment grid. The information is collected quarterly by the provincial PBF technical team through quality assessment. The health center with CHW system that meet defined functionality standards is the health center that has always had 50/50 on the indicator 17 of the PBF quality assessment grid in the four quarterly assessment sessions. Data for the quarter July-September 2016 are still missing, will be available in December 2016.

Percent of COSAs that meet defined functionality standards

Functional COSA is defined as COSAs that meets all of the following standards: participate in annual planning; have monthly meetings, with verified meeting reports; discuss the financial situation of the health center; and evaluate action plans. The information is got from facility-based survey conducted through interviews with COSA members. The 2016 target was 72.7%; the achievement is 61.1%. The target was underachieved because during year 3, COSA strengthening targeted those that were found not meeting the functionality standards by SARA. However, even those supposed to meet the functionality standards according to SARA were vulnerable because their members had never been trained, they are likely to lose any functionality criteria at any time. During year 4, COSA strengthening will target all those that have not been trained yet.

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services

Planned for Y3	Achievement and results	Comments
Organize four-day training sessions for IHPB technical leads in QI tools and coaching skills	Achieved	23 IHPB staff trained and capable of coaching QI teams to conduct small improvement projects.
Organize four-day training sessions for Muyinga coaches.	Achieved	6 coaches and 16 other participants have been trained in Muyinga.
Conduct joint coaching visits to established QI teams (QIT) in 21 health facilities of Kayanza and Muyinga to define implementation QI action plan.	Achieved	21 QIT in Muyinga and Kayanza received coaching visits, along with QIT of Kirundo and Karusi.
Mentor coaches through joint coaching visits during supportive supervision	Achieved	46 mentoring visits documented in reports.
Organize two to three learning sessions per province.	Partially Achieved	6 learning sessions held: in Karusi (2) Kirundo (2), Muyinga (1) and Kayanza (1).
Document QI work through technical briefs and case study	In progress	First draft of technical briefs and case study per health province developed.
Train 15 curative care providers in Kayanza Province on integration of FP into MH and HIV services	Achieved	63 health providers trained.
Train 11 curative care and child care providers in Karusi on integration of FP into MNCH services	Achieved	11 health providers trained.
Train 15 curative care providers in Kirundo on malnutrition screening and care	Achieved	23 health providers trained.

During the first three years, jointly with the MPHFA, IHPB has supported the design and implementation of a large-scale improvement effort to integrate essential services in 46 health facilities (40 HCs and 6 hospitals) throughout the 12 districts of IHPB-supported provinces. In partnership with district health teams, IHPB established a network of 24 coaches (2 district supervisors per health district) to support the facility-based quality improvement (QI) teams to achieve their integration objectives through the testing and implementation of changes in service delivery. IHPB manages this improvement effort through the Improvement Collaborative model, where QI teams meet regularly during "learning sessions" to share results of their work and identify changes that led to better integration of services. The aim of this demonstration phase is to define a package of effective changes to become best practices that will be extended to all facilities. During Y3, IHPB supported the QI teams to identify and test the changes that will be sustained and extended to all facilities in the remaining years of the project

Organize a four-day training sessions to train IHPB technical leads in QI tools and coaching skills

From October 14 to 16, 2015, IHPB organized a three-day training session on the QI model and collaborative approach for 22 IHPB technical staff from Bujumbura and field offices. The purpose of the workshop was to strengthen their process improvement skills and build common understanding of the project staff on improvement concepts so that they are more effective in their support to district health systems and partners, through activities such as: mentoring district coaches, coaching QIT, tracking their progress and assessing their needs.

Participants became familiar with a few QI tools: tracking table of norms reported in data collection tools, QI action plan form, monitoring plan, job aid for QI team composition form, job aid for meeting organization, job aid for meeting report, QIT functionality follow-up form, and follow-up of decision-making form.

Organize a four-day training session to train Muyinga coaches in QI model and collaborative approach

From 24 -27 of November 2015, a four-day coaching training workshop was held in Muyinga province, completing the coaching structure in all 4 provinces with 6 additional coaches: supervisors from district health offices (6). Hospital directors/delegates and chief of nursing (6), in charge of health centers (6) participated in the session to learn about quality improvement concepts. The purpose of the workshop was to build the skills of coaches to support Quality Improvement Teams who are working to integrate Intermittent Prevention Therapy of malaria in pregnancy (IPTp) into ANC services.

Conducted joint visits to establish and coach facility-based QI teams on site in Kayanza health province

In Collaboration with 3 district supervisors trained as coaches, IHPB conducted on 26-30 October, 2015 joint coaching visits in Kayanza health district to assess and support the work of the QIT in five facilities. IHPB conducted a similar round of coaching visits on 3-6 November, 2015 focused on Musema and Gahombo health districts targeting ten facilities where 97 providers (QIT`s members) who are trying to integrate FP services into MCH and HIV services.

Conducted joint visits to establish and coach facility-based QI teams on site in Muyinga health province

Following the coaching training, in collaboration with the Muyinga health province and Gashoho and Giteranyi trained coaches, IHPB organized a three-day joint coaching visit to support 2 QIT to integrate malaria prevention activities into MCH services in Gasorwe and Kamaramagambo health centers.

Mentor coaches through coaching visits during supportive supervision in Kayanza, Kirundo and Muyinga health provinces

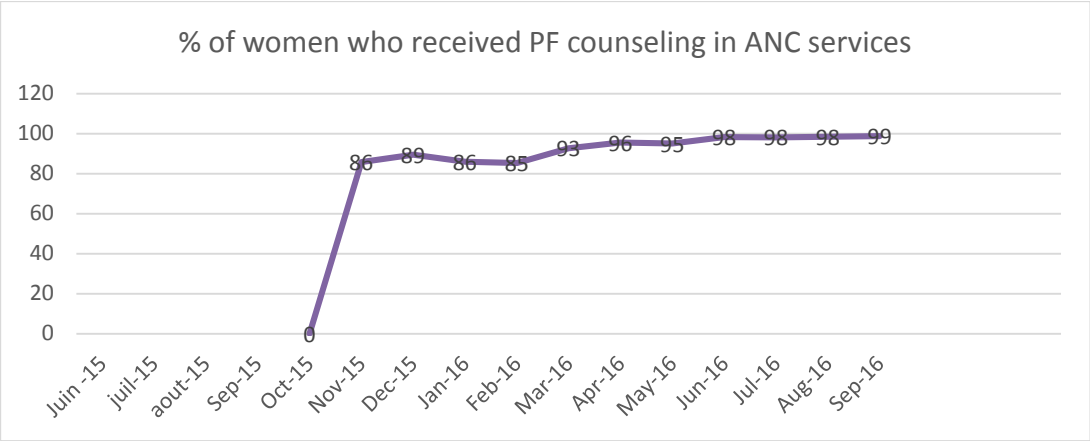
During joint coaching visits, the focus of IHPB technical advisor is to support the facility-based QI teams achieving their integration objectives. This is complemented by the mentoring of district-based QI coaches in order to develop their capacity to coach the QIT.

Mentoring visits in Kayanza health province

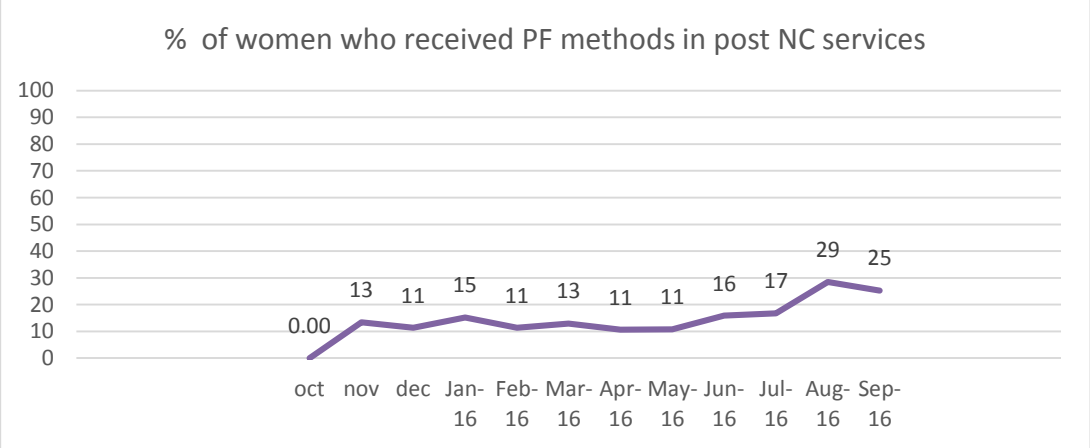
In partnership with Kayanza, Gahombo and Musema health districts where 15 facilities are integrating family planning in maternal health and HIV services, IHPB conducted mentoring visits with district supervisors trained as coaches on April 4-8, 2016. During the visits, we observed that FP counselling is integrated in ANC services in most of the sites (13 out of 15 facilities) except Musema and Gahombo hospitals because they don`t have ANC services while 9 out of 15 are HIV service delivery pilot sites which are providing integrated voluntary family planning.

Data analysis from the improvement monitoring database shows the following results:

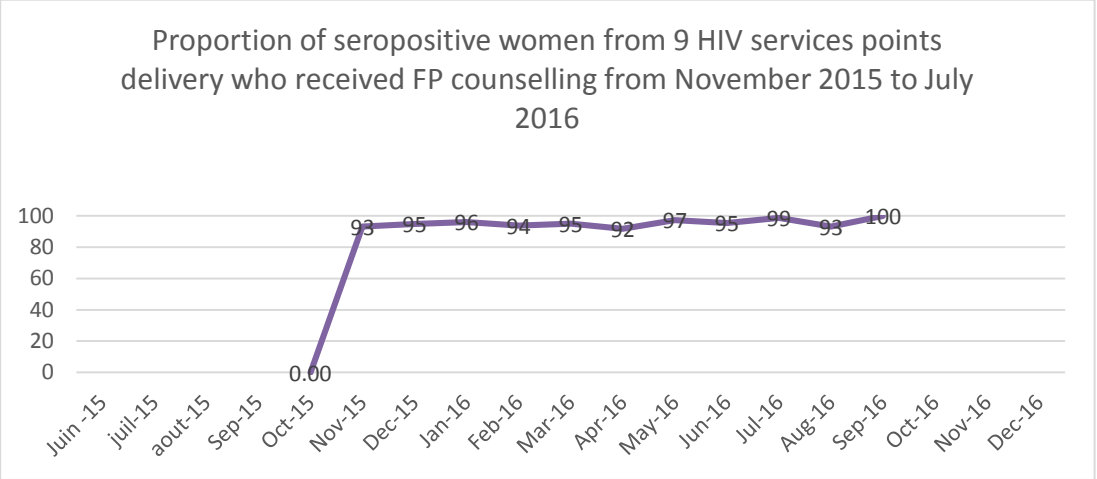
- A total of 24,535 women received FP counselling out of 25,443 (96%) women who attended ANC in the 15 facilities during October 2015 to August 2016.
  Progress of this indicator is shown on run chart below:



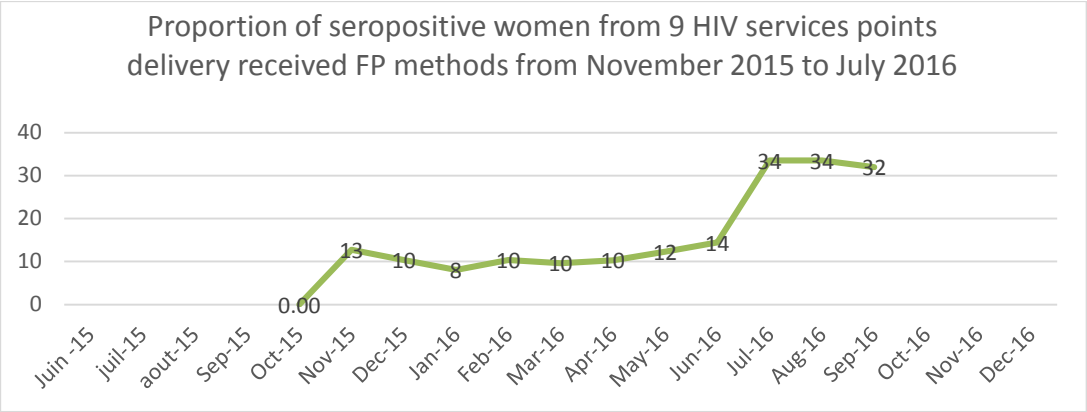
- A total of 1,687 out of 11,463 (15%) women who attended Post NC from October 2015 to August 2016 accepted and received FP methods.



- A total 6,605 out of 6,775 (94%) seropositive women from 9 HIV services points delivery received FP counselling from November 2015 to July 2016

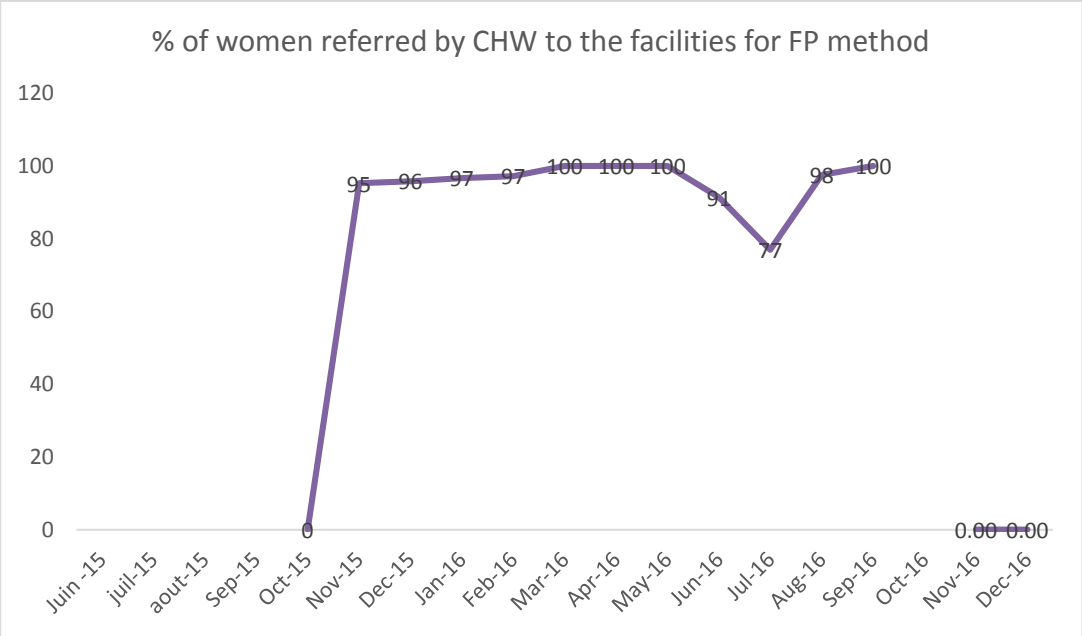


- A total of 1,096 out of 6,742(16%) seropositive women received FP methods during the same period. Progress of this indicator is shown on run chart below:



There is also progress in Community PF integration where Health Promotion technicians go in the community to provide the DMPA to women counseled by CHW and who accept methods.

- A total of 1,098 out of 1,150 (95%) women were referred by CHW to the HC for methods during the same period. Progress of this indicator is shown on run chart below:



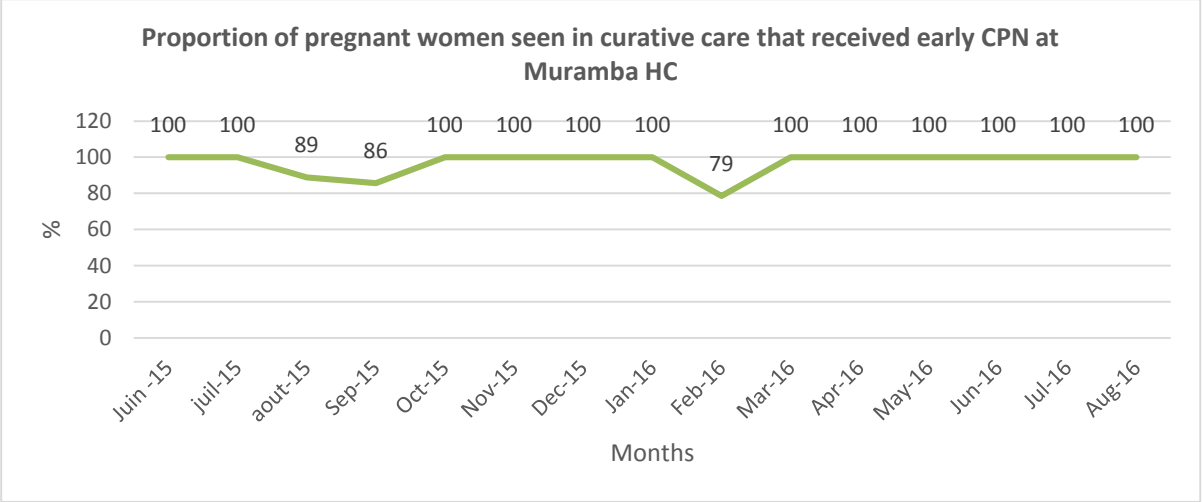
We identified a QI success story from the Kavoga HC in charge that we are planning to publish: "*Before QI, family planning coverage was low and is now increasing*", she said. Before integration, there was a single unit for both immunization and post-natal services. The main changes that led to improvement are: a) assigning permanent qualified personnel in immunization and post-natal care. b) identifying and prioritizing for services women who bring children for immunization and who are also in need of postnatal care, c) providing FP counselling and accompanying those who accept a method, so that a woman receives immunization services for a child, postnatal care and FP methods on the same day and in the same structure.

In Kavoga HC, data are collected and transmitted monthly to the next level, data reported monthly are consistent with those recorded in registers, analysis of the data is made before the transmission, the referral notes from the CHW are filed and available at Kavoga health center and documents are very well filed at the same facility.

The main challenges encountered by some facilities are: QI documents not well filled; data not collected regularly; no calendar of meetings for members of the QIT; lack of trained staff in contraceptive technology. At the end of the visit, recommendations were done to each QIT according to challenges encountered such as holding regularly the meetings on scheduled timetable, write and classify the meeting minutes made within 2 days.

Mentoring visits in Kirundo health province

The visits covered 17 facilities that are integrating early ANC, GBV, screening for malnutrition and HTC services into curative care. We found that QIT are functional in almost all four facilities of Vumbi health district, except at Rushubije facility where three QIT members including the chairman and the secretary were assigned to others facilities. At Muramba health center, all scheduled meetings are held with good availability of archived reports, areas of integration are known by all members, the improvement plan is developed and executed monthly, very dynamic and well organized QIT, meetings are well planned and displayed, tasks description in the target services of integration exists and is displayed. The same findings were also observed at Kabanga health center of Busoni health district.



The main challenges encountered in some other facilities include: no updated process diagram, meetings not scheduled (no displayed planning), lack of job descriptions in the target service integration, stock-out of pregnancy test in curative care. Some new ideas of change have been identified like: track malnutrition systematically (at waiting room) to all children under 5 years received at the HC.; Track malnutrition systematically all children under 5 years in the community by ASC then refer cases found; Strengthen the waiting room by adding another unit qualified.

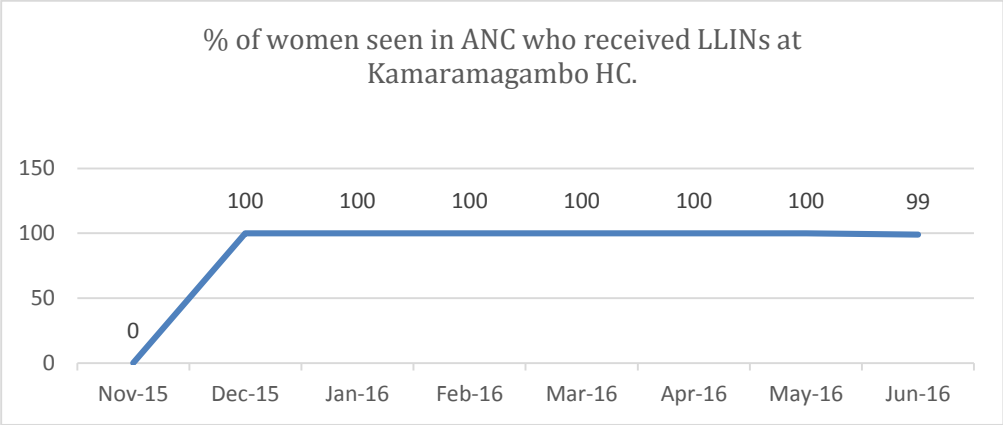
Mentoring visits in Muyinga health province

A mentoring visit was conducted in May, 1-6, 2016 in 3 facilities that are integrating malaria prevention into ANC care. Teams are making progress: collective health education on early ANC and delivery of Intermittent Preventive Treatment in pregnancy (IPTp) in ANC at Kamaramagambo HC; resources are available (SP, LLINs, Albendazol, Iron and VAT), the IPTp is provided and observed in ANC, the QIT meets once a week, LLINs is provided from ANC service at Kamaramagambo HC.

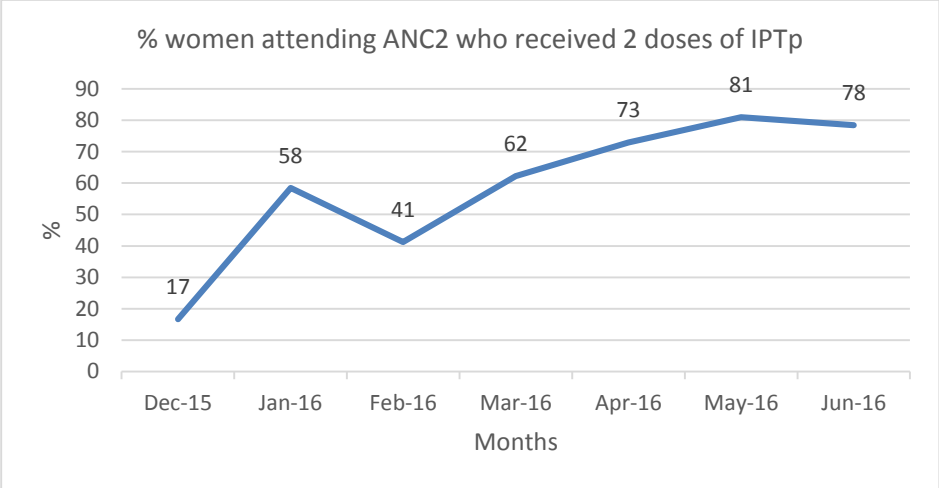
Data collected and aggregated for the three pilotes sites show the following results:

- A total of 1,331 out of 1,714 (78%) women attending ANC from December 2015 to May 2016 received Long-Lasting Insecticide Treated Nets;
- A total of 596 out of 1,245 (48%) women attending the second ANC received two doses of IPTp

At Kamaramagambo HC, the run chart below shows that all women who attended ANC1 received LLITN at Kamaramagambo in Giteranyi health district because it is provided from ANC service instead of the delivery room



The run chart in below shows improvements in IPTp coverage at Kamaramagambo HC.



Organized 6 Learning Sessions (LS)- in Karusi, Kirundo, Kayanza, Muyinga health provinces

MPHFA in collaboration with IHPB has held six learning sessions respectively on January 12 to 14, 2016 for the first LS, on July 4 to 8, 2016 for the second LS at Karusi, on January 20 to 22, 2016 and September 26 to 30, 2016 for respectively first and second LS at Kirundo, on July 26 to 29, 2016 for the first LS at Kayanza and in August 29 to 1 September at Muyinga health province for its first LS.

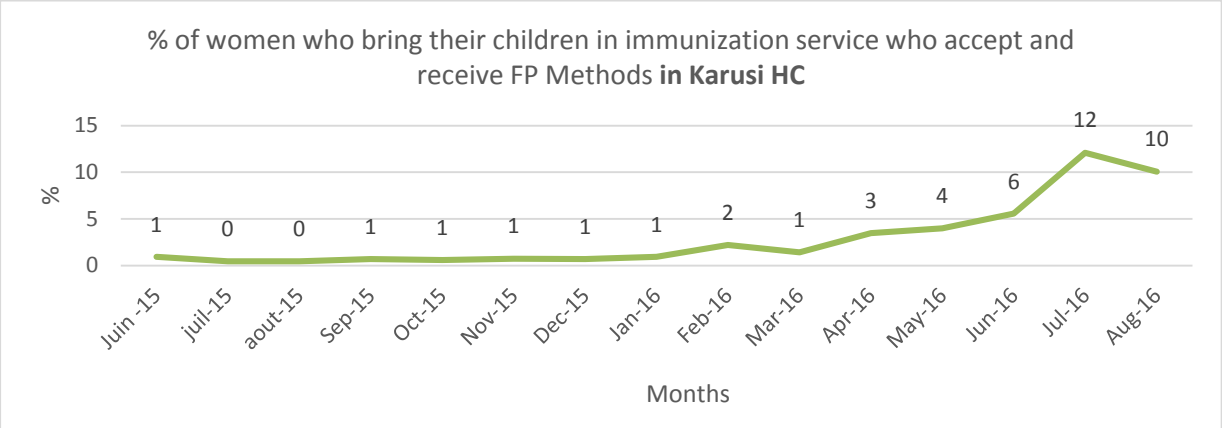
A learning session brings together representatives of all QI teams, their coaches and district managers to discuss progress of their work, results, and share good practices that may lead to better integration of services.

Karusi Learning Session:

The Karusi learning session brought together 33 participants during the first LS and 35 participants during the second one.

Lessons learned:

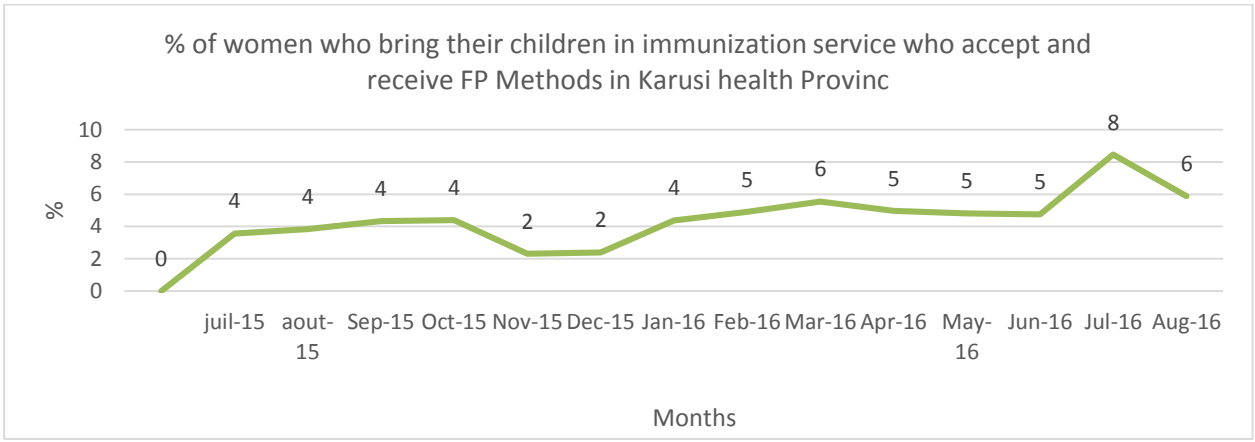
i) The learning sessions for QI quickly improve integrated services since underperforming sites learn from performing sites; some sites like Karusi HC has much improved in second LS compared to the first

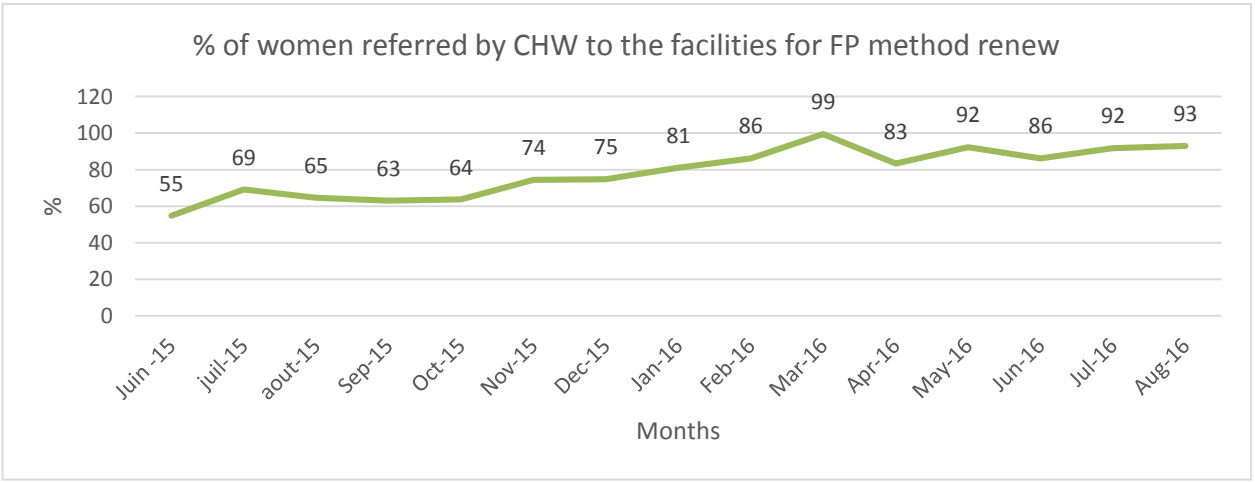


LS;

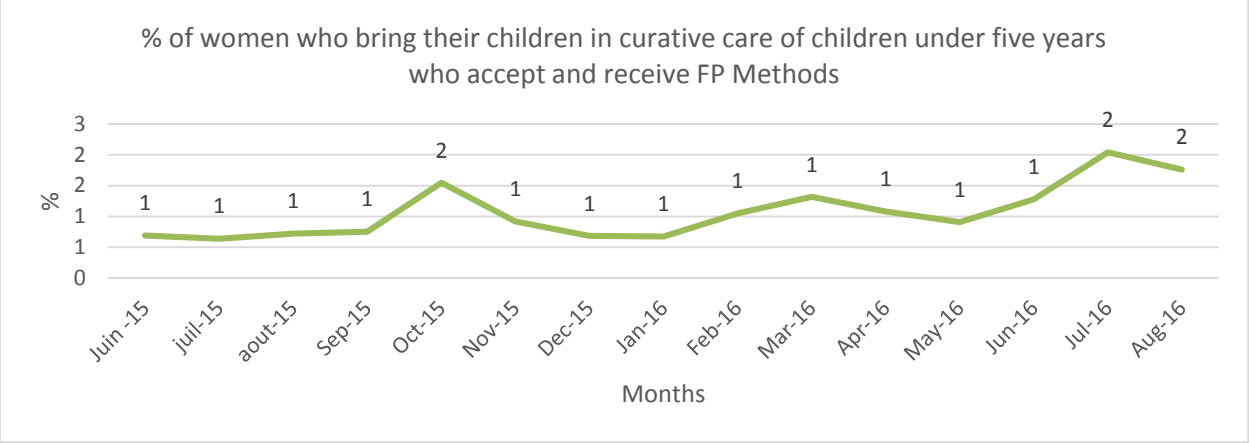
ii) Identified three indicators in progress related to – integration of FP in immunization services (Karusi), – integration of FP in community (Karusi);

Integration of FP services into immunization services in facilities and into community-based services are feasible and led an increase demand in FP services





iii) The integration of FP services (Karusi) is difficult to introduce in women with sick children.



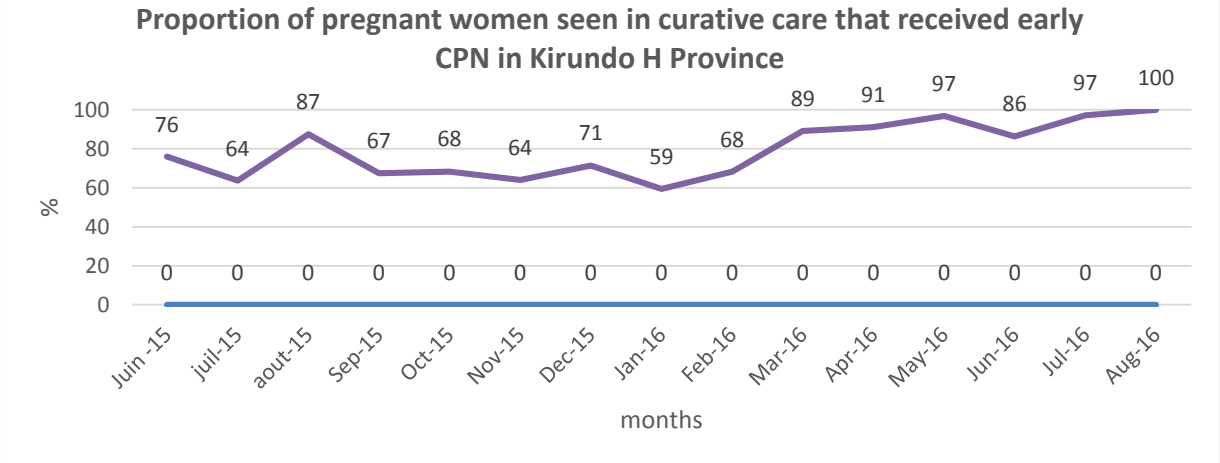
Challenges encountered are: Religious barriers for modern FP methods and also some women do not spontaneously accept methods because they need approval of their husbands.

Kirundo Learning Session:

The Kirundo learning session brought together 57 participants in first LS and 56 participants in second LS including provincial medical director, district medical directors, district HIS staff, health center in-charges.

Lessons Learned:

Integration of early ANC into curative care service and delivery of early ANC1 services the same day contributed to an increase in women who completing their 3 ANC visits by the third quarter. The main change is that all providers search actively pregnancy in every girl and woman of childbearing seen in curative care and offer a free pregnancy test to those who mention a delay in menstruation and who are not using a contraceptive method in the same room by the same provider.



- When a pregnancy test is negative, clients refuse to pay and refuse to use other services, which prompted providers to offer the pregnancy test for free, whatever the result is.
- Providers reported that integration of HTC into curative care contributed to fortuitous discovery of seropositive cases and their treatment.

Learning session in Kayanza:

IHPB and the Kayanza health province held a learning session (LS) that brought together 42 participants. In that province 15 out of 45 (33%) facilities are integrating FP into MCH while 9 out of 45 (20%) are integrating FP into HIV care services. During the learning session, discussions focused on FP integration into HIV care services especially on notification of women who receive FP counselling and those put on FP methods. Only new cases were counselled and reported in reports. Since they follow up a cohort of patient, the consensus obtained is that all 9 HIV delivery points must provide FP counseling even to those already under FP methods in order to stay on methods as long as possible and report both women ancients and new counselled and put under FP methods.

Learning session in Muyinga:

The Muyinga LS brought together 26 participants, including a chairman and a member of QIT per site, 2 participants in charge of health information system of Muyinga provincial bureau, Gashoho, Muyinga, Giteranyi health districts, 3 health districts supervisors, 3 coaches and 4 IHPB staffs. Also the provincial medical director and the district medical directors were present.

Lessons learned: Providers reported that stock out of Fansidar was reduced since they started to correctly calculate the expected number of pregnant women and order Fansidar (SP) based on the Average Monthly Consumption.

- Sensitization on early ANC in community contributed to increased number of women receiving three doses of IPTp minimum during pregnancy;
- The integration of malaria prevention in pregnant women into ANC has significantly reduced the rate of low birth weight, the number of intra uterine deaths as well as abortions.

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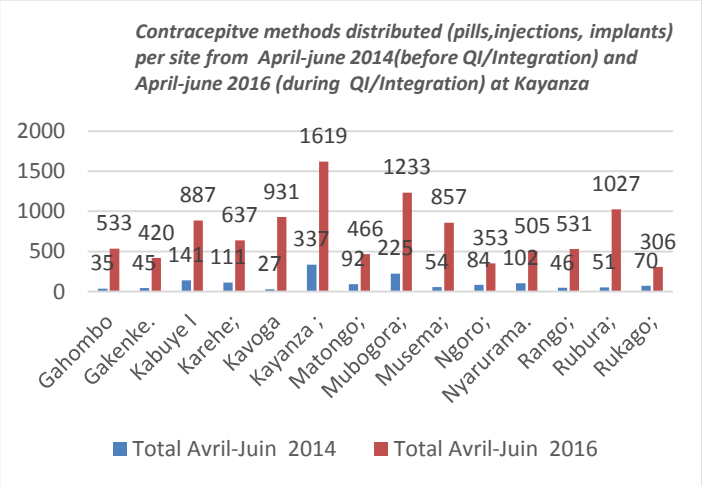
Document QI work through technical briefs and case study

A detailed technical report on the QI Collaborative, with a focus on process, has been drafted, following the FHI 360 template for QI stories. This live document is being updated gradually as team's progress through the stages of the model and results become available. It remains to be completed with the lessons learned over time through learning sessions and with final results.

At the end of year 3, preliminary results in figures below show a significant increase in FP methods distributed to new clients in sites involved in QI/Integration in Kayanza and Karusi health provinces.

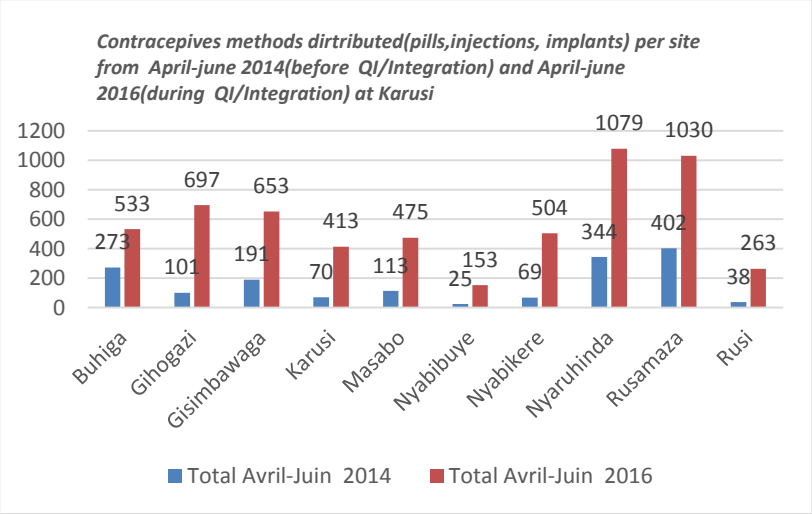
The chart below shows an increase of FP methods distributed during the integration effort compared to the period before QI/Integration in Kayanza province, attributed partially to the following changes: ▪ Provide FP counseling to every woman attending ANC. ▪ Assign permanently a qualified staff in immunization and postnatal care services.

▪ Identify in the vaccination service, the women who need postnatal care and vaccinate their children first; accompany them in postnatal care service to offer counseling on FP, ▪ The same provider



who provided counseling provides the FP method, ▪ Make available contraceptive methods in counseling room for HIV.

The chart below summarizes Contraceptives methods distributed to new clients (pills, injections, implants) per site from April-June 2014 (before QI/Integration) and April-June 2016 (during QI/Integration) at Karusi province. Changes tested are as follows: ▪ Conduct (every morning) collective and individual health education on FP, targeting women who bring their children for immunization services, ▪ Provide FP services every day to avoid missed opportunities.



▪ Accompany the client who accepts a FP method or service to the delivery space, ▪ Sensitize CHWs to provide FP counseling to every woman who bring children for CCM of malaria, and provide a referral note to those who accept a method. Those ideas change contributed significantly to an increase of new clients who received family planning methods during QI/integration period.

Organized two-day field visits in Karusi to collect success stories about family planning and data review

In partnership with Buhiga and Nyabikere health districts, IHPB conducted a field visit to collect success stories about family planning and data review at Masabo and Rusamaza health centers identified during the learning session as sites that have promising ideas for change and good indicators related to FP integration into immunization services.

Train 15 curative care providers in Kayanza Province on integration of FP into MH and HIV services

In collaboration with the Health Provincial and district Bureaus (BPS, BDS) of Kayanza province, IHPB support the five-day training session of healthcare providers in charge of HIV services on integration RH/FP/PMTCT and HIV to integrate family planning in HIV/PMTCT services. The training session has been held on September 28 to October 2, 2015 in Kayanza province. The module used is the national manual: "MANUEL DE REFERENCE SUR L'INTEGRATION SR/VIH/PTME". A total of 63 participants took part in the training session including 25 males and 38 females. The knowledge of the participants has been evaluated before the training courses and after the training session. The results show improvements of knowledge of the participants as following: the mean in pretest is 21/48 and in posttest is 36/48. The low score in pretest and posttest is respectively 12/48 and 25/48; the high score in pretest and posttest is respectively 32/48 and 43/48.

Train 11 curative care and child care providers in Karusi on integration of FP into curative consultation services

In collaboration with the Health Provincial and district Bureaus (BPS, BDS) of Karusi province, IHPB support the five-day training session of healthcare providers in charge of curative consultation for under five children on family planning counselling in order to integrate family planning in curative consultation.

The training session has been held in January from 18 to 22, 2016 in Karusi province. The purpose was to strength the competences and skills of healthcare providers in offering family planning counseling while providing curative consultation services. The module used is the national manual on contraceptive technology (MANUEL DE REFERENCE SUR LA FORMATION EN TECHNOLOGIE CONTRACEPTIVE). A total of 15 participants took part in the training session including 11 males and 4 females.

The knowledge of the participants has been evaluated before the training courses and after the training session. The results show improvements of knowledge of the participants as following: the mean in pretest is 28/44 and in posttest is 34/44. The low score in pretest and posttest is respectively 24/44 and 28/44; the high score in pretest and posttest is respectively 37/44 and 39/44.

Train 15 curative care providers in Kirundo on malnutrition screening and care

Training of health providers to integrate screening and managing of malnutrition in curative services

In partnership with the Kirundo health districts Bureaus, IHPB organized five (5)-day training sessions on screening and managing of malnutrition for healthcare providers. The training session took place from March 14th to 18th, 2016 and 23 participants among them 16 males and 7 females. The purpose of the training was the integration and quality improvement of malnutrition screening and care in curative consultation and the training manual used is "PROTOCOLE NATIONAL DE PRISE EN CHARGE INTEGRÉE DE LA MALNUTRITION AIGUË (PCIMA)". We noticed progress because the mean of score in pretest and posttest is respectively 24.15/40 and 28.45/40. The lowest score in pretest is 18/40 while is 22/40 in posttest. In the other hand, the highest score in pretest is 31/40 while is 34/40 in posttest.

In Y4, IHPB will build on the solid improvement platform that has been established in order to extend the best practices which will be identified during the third LS in each health province, define the change package with the provincial and district teams and develop a strategy for extension of the best practices (changes that led to improvements) to the remaining facilities per province, based on availability of human resources.

Sub-CLIN 2.3 Increased capacity of providers and managers to provide quality integrated health services

Planned for Y3	Achievement and results	Comments
Continuously update the IHPB training database	Continuous	The excel database was continuously updated, with a total of 6,563 training records for 4,038 learners entered as of September 2016.
Continue developing post-training assessment tools	Continuous	Two tools were set up to better track trainings and post-training supportive supervision visits. With IHPB staff, a draft of an "integrated instrument" for improvement and capacity strengthening is under development that accounts for post-training assessment. An internal "pilot" review of the integrated instrument was conducted. The external pilot will be conducted using selected paper-based modules in the first quarter of Y4.
Plan and contribute to measuring health workers' attitudes	Continuous	Collection of data planned for October 2016
Plan and coordinate supervision visits supported by IHPB	Achieved	In the post-training follow-up framework, joint supervision visits were conducted in the following provinces: Muyinga (27), Kayanza (15), Kirundo (3)
Contribute to design and implementation of the supervision system assessment	Continuous	Integrated instrument for improvement and capacity strengthening will help the project to assess the system. The variables will be included to allow the supervision system assessment.
Participate in planning district in-service training activities	Planning process underway	

During Year 3, (October 2015-September 2016), the project focused on capacity strengthening across mandated health domains and cross-cutting areas through training and supervision. In addition, efforts were made to better manage strategic information on trainings, which requires additional attention in Y4. The following Sub-Clin 2.3 activities were conducted:

Continuously update the IHPB training database

The IHPB database was continuously updated and reformatted using standard data variables in FY2016. As of the end of Y3, it includes a total of 90 unique trainings. The trainings were delivered through 173 sessions. In total 4,038 learners benefited from IHPB training over the course of the project, with many completing more than one training. In Year 3 alone, a total of 53 trainings were conducted at 101 different sessions, resulting in a total of 3,649 individual learner sessions.

In support of the development of an evidence-based Year 4 capacity building plan, an analysis was initiated to show the training's coverage across the IHPB's integrated health topics and by district and facility. An overview of the total number of learner sessions in Y2 and Y3 (from the project start through September 2016) by training domain (the four priority health areas, plus service integration, as well as community health and cross-cutting system domains [HSS, M&E, QI and SCM]) are shown in Figure 1.

In addition, preliminary results on training coverage by province, health system level, and technical areas are shown in Figure 2. It should be noted that these results count separately each learner session experienced by an individual learner (i.e., one health provider who is trained in both family planning and HIV is counted twice in Figures 1 and 2). However, the training database has been updated to include individual trainee records and IHPB-supported training profiles by district manager, health provider, and CHW can be examined.

Figure 1: Number of IHPB-supported learner sessions by domain, Y2 & Y3

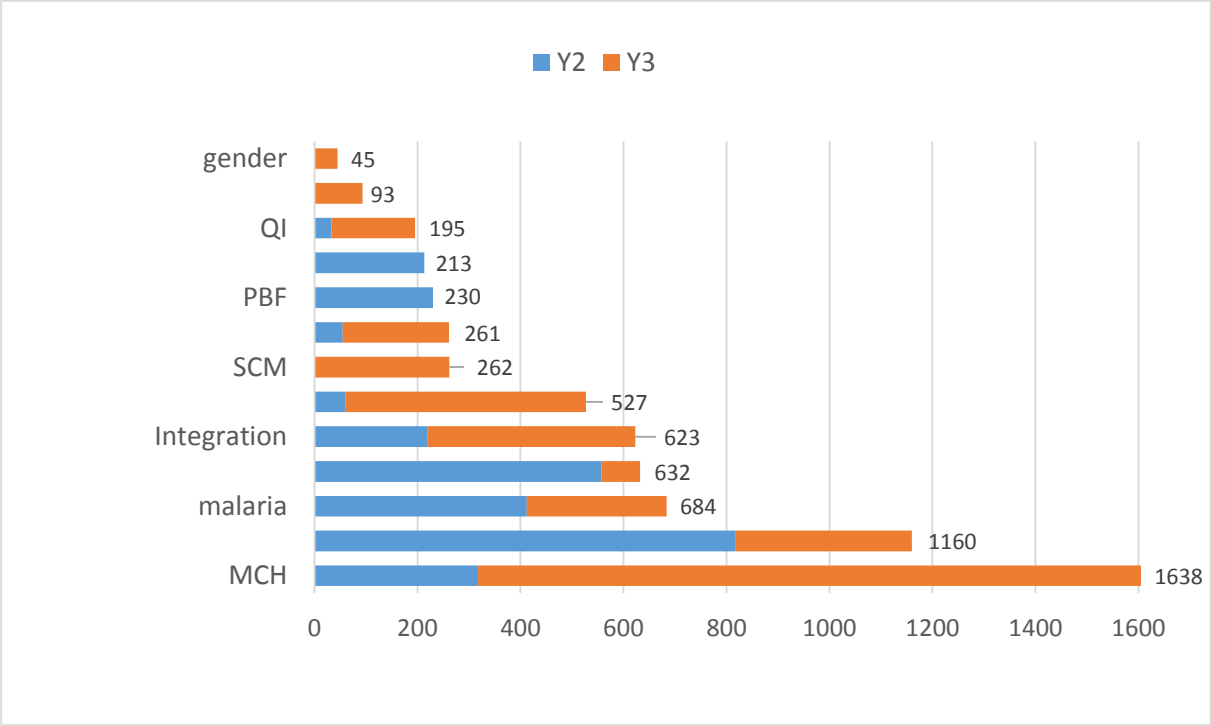
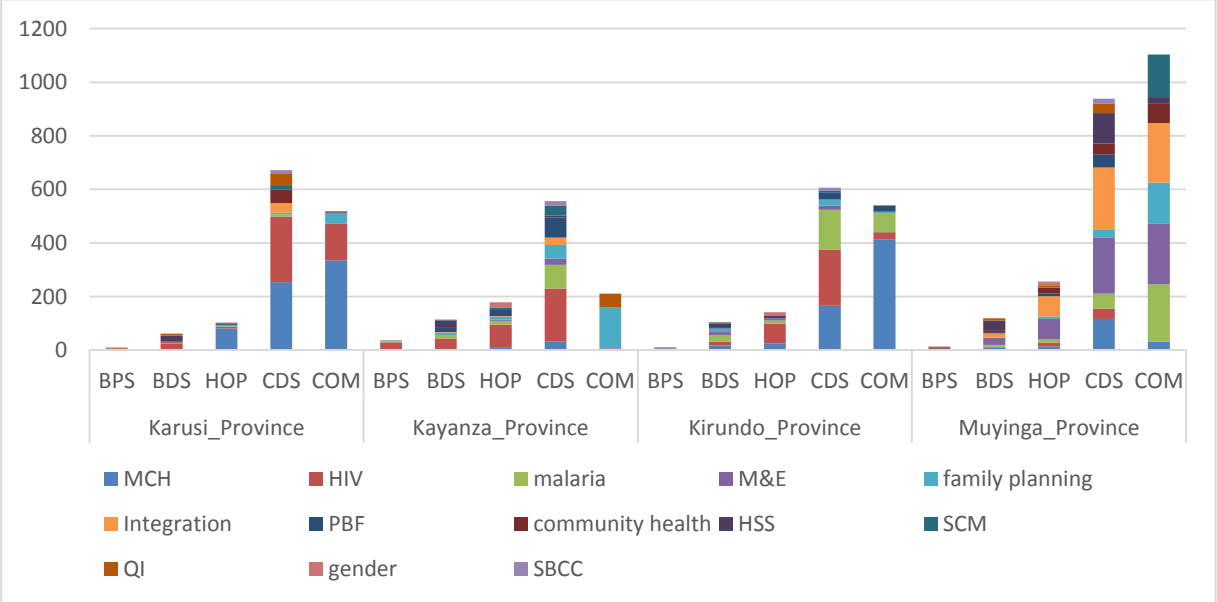
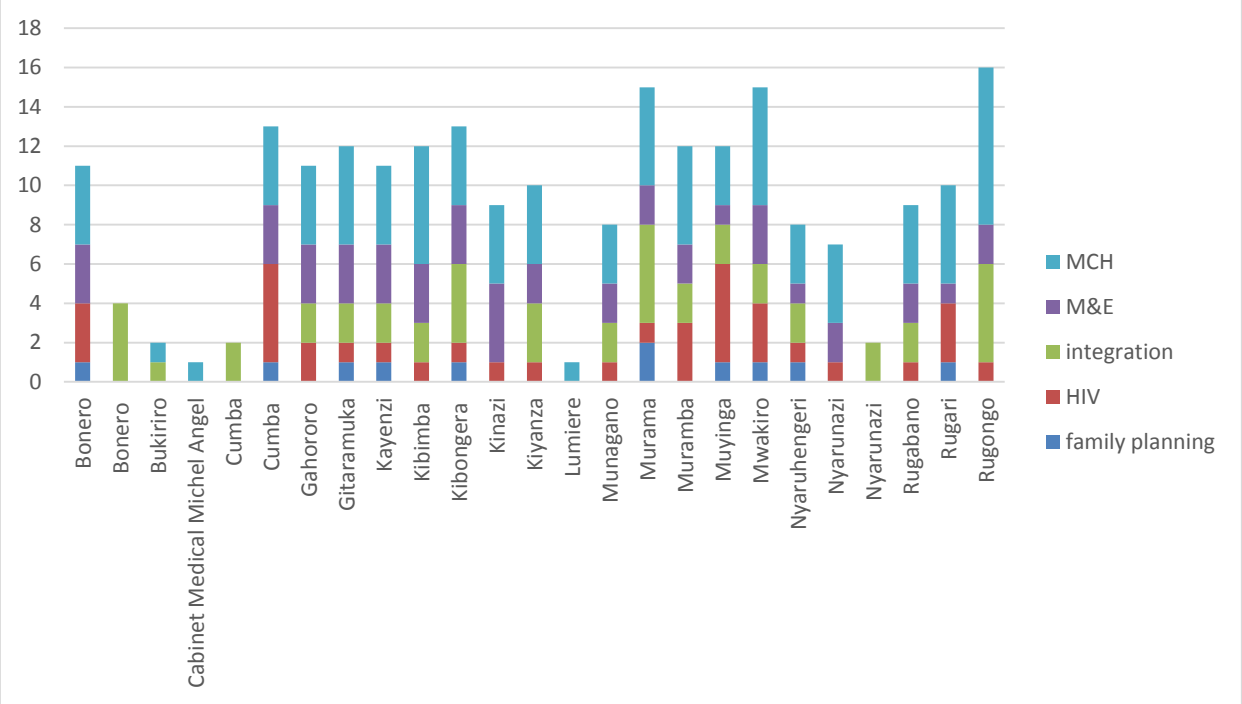


Figure 2: Number of IHPB learner sessions by province, health system level, and domain, Y2 & Y3



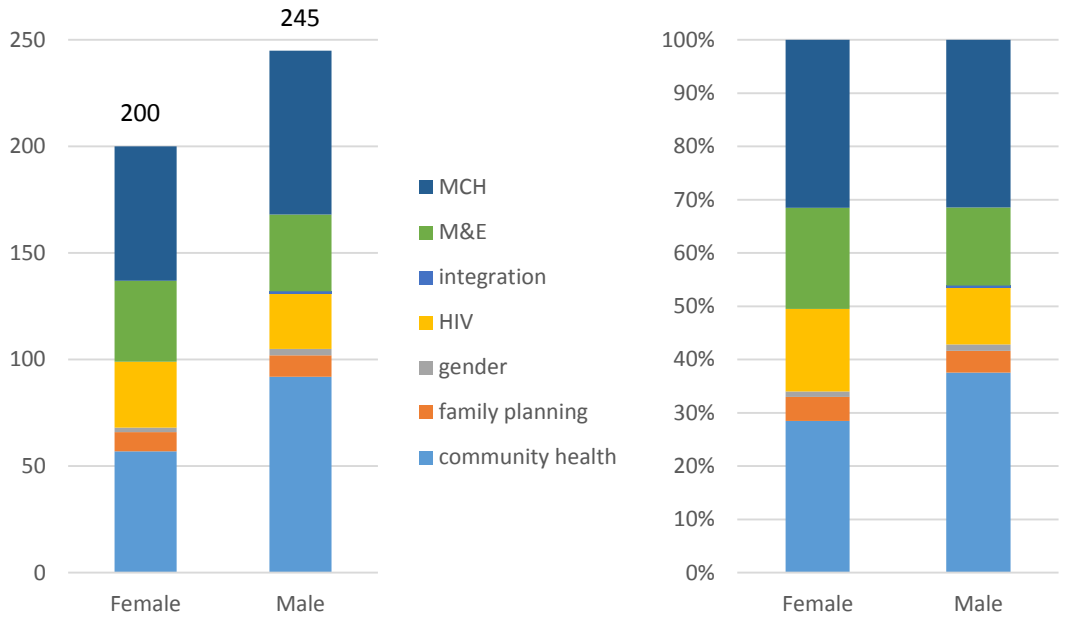
The updated training database also allows for facility-level review of training coverage. For example, in Muyinga district, there were a total of 31 health facilities (including both public and private) supported through IHPB trainings, with 445 learner sessions. The training coverage by facility and domain can be found in Figure 3. Data show that coverage of the four priority health areas is generally uniform and adequate, with the exception of family planning, which was trained on in only 11 of the 31 facilities. Cross-cutting training domains, such as gender and QI do not have high training coverage, although these domains are less theoretical; facilities would likely benefit from more practical support in these areas.

Figure 3. Number of IHPB-supported training sessions by health system level and domain in Muyinga district, Y2 & Y3



The database also allows for review of training coverage by gender. Figures 4a and 4b show number of training sessions per domain by gender. Overall, there are more men trained then women, but in general they participate in the same kind of trainings, with men attending a slightly higher proportion of community health trainings, and women a higher proportion of HIV and M&E.

Figure 4a and b. Number (a, left) and Percentage (b, right) of IHPB-supported training sessions domain and gender, Muyinga district, Y2 & Y3



These analyses, among others, will be used to identify which facilities have staff recently trained in these areas, the gap to cover and the level of integrated health skills existing at the facility level.
The project team is considering how the use of tablets and digital data collection at the training sites by trainers and trainees, could improve the efficiency and accuracy of trainee tracking, as well as contribute to better human resources management in general.

Continue developing the post-training assessment

Two tools were developed to collect data and aid in post-training assessment. First, a post-assessment tool was developed that will be completed at the end of each training. This is to serve as a method of evaluating post-training knowledge. Second, each trainee develops a post-training action plan, detailing how they plan to apply what they have learned in the workplace. These actions will be assessed during supervision visits in the quarter following the training, to evaluate the level at which training knowledge translates to practice.

Plan and coordinate the supervision visits supported by IHPB

In Y3, joint supervision visits were conducted in 45 health facilities in Muyinga (27), Kayanza (15), Kirundo (3) provinces in collaboration with the provincial staff of IHPB and BDS staff. Fifteen trainees were followed up in Supply Chain Management, twelve in malaria and eighteen in health information system during those supervisions. A calendar of post-training follow-up dates was set up for the following quarter.

An annual calendar of supervision visits supported by IHPB was set up to coordinate the use of the project's post-training assessment. In accordance with the follow-up schedule for IHPB-supported trainings, this calendar will help to coordinate and track supervision visits moving forward.
Project staff including the HSS team, has initiated the development of an integrated instrument for assessment, improvement and capacity building, referred to as the "integrated instrument". The instrument's service-based modules were drafted and piloted internally through team-based role plays in

Y3, Q4. The ultimate goal is to integrate this tool for facility improvement, capacity reinforcement, and supervision support using Open Data Kit (ODK) for deployment on the project's handheld tablet devices.

It is anticipated that digital data collection will improve the speed, accuracy and efficiency of supervision and related reporting on the PTO's facility support visits, as well as implementation activities. It is also anticipated that the integrated instrument can help to optimize and coordinate post-training supervision visits with routine facility visits. Key information generated by the instrument will be disseminated to relevant project stakeholders, including to district health teams, the project's M&E unit, technical specialists, and/or province-based management. Select data that relates to the project's mandatory results is planned to be compiled onto a dashboard to promote targeted, evidence-based approaches for facility strengthening and supervision.

Progress and discussion on Sub-CLIN 2.3 indicators

Indicators	**Target FY2016**	**Achieved FY 2016**				**%**
		October-December	**Jan-March**	**April-June**	**July-September**	Total
2.3.1 Percent of trained health providers, managers and CHWs who perform to a defined standard post-training [Mandatory Result]	95%	0%	88,8% (n=27)24/27	100% (n=8)8/8	90%(n=10)9/10	91% (n=45) (41/45)
2.3.2 Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [Mandatory Result]	90%	89.9% (n=217)	91.9% (n=149)	98.0% (n=557)	91.4% (n=430)	94.6% (n=3885) 93.9% (n=1353)
2.3.3 Percent of trained health care staff who report positive attitudes (composite indicator) about work and the workplace [Mandatory Result]	62%	-	-	-		79.2%
2.3.4 Percent of health facilities with at least 80% of clients reporting satisfaction with services received [MR]	100%	-	-	-		PBF source.
2.3.5 Number of health care workers who successfully completed an in-service training program	1,940	594	423	574	241	1,832 (94.4% of FY16 target)
2.3.6 Number of community health/para-social workers who successfully completed a pre-service training program	1,436	0	822	282	340	1,444 (100.6%) of FY16 target)

% of trained health providers, managers and CHWs who perform to a defined standard post-training

With a target of 95%, on average, 91% of those trained performed to a defined standard post-training. During second quarter (January-March, 15 trainees in Supply Chain Management in Muyinga and 12 trainees in new guidelines of malaria case management were assessed in Kayanza after trainings and 24 (88.8%) performed to their post training assessment. During third quarter (April-June), eight trainees in Health Information System in Health Facilities in DS Muyinga and eight (100%) performed to their post training assessment. During fourth quarter(July-September) 10 trainees in Health Information System in

Health Facilities in DS Muyinga and nine (90%) performed to their post training assessment. It is important to increase the number of learners in monitoring post training to increase the impact of such monitoring on improving service quality. Note that during the October-December quarter, no assessment was conducted because of tools that were not available.

% of supported health providers, managers and CHWs who have demonstrated improvement post-training

Pre and post-test are regularly given and results are collected and the progress by trainee is estimated.
We believe that we will maintain up the target which was estimated at 90%.
A total of 3,649 learning sessions occurred during Y3. Of those who completed assessments, 93.9% demonstrated improved scores from pre-test to post-test.

Number of health care workers who successfully completed an in-service training program

A target of 1,940 managers and health workers were anticipated to be trained in Y3. At the end of Y3, 1,832 health workers were trained, which represents 94% of the annual target.

Number of community health/para-social workers who successfully completed a pre-service training program

In total 1,444 CHW were trained which represent 100% of the 1,436 CHWs planned to be trained.

% of trained health care staff who report positive attitudes (composite indicator) about work and the workplace

The target for positive health worker attitudes is set to 69%. In Y3, this stands at 79.2%.

% of health facilities with at least 80% of clients reporting satisfaction with services received

This is a PBF indicator with a target of 100%.

CLIN 3: Strengthened Health Systems and Capacity

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas

3.1. a. Work with provincial and district health bureaus to progressively strengthen district level capacity and performance in managing the decentralized health system

Planned for Year 3	Achievement and results	Comments
Identify, reproduce and distribute all current national health policies, protocols, and guidelines needed by FOSAs	Achieved	Current national guidelines and other related documents have been distributed according to plan.
Build capacity of 12 supervisors in preventive maintenance for medical equipment	Not achieved	The 12 supervisors were not available for the period when trainers from ALCHEM and HMS were available to organize and conduct the training.
Train lab technicians of the six district hospitals to perform clinical laboratory tests	Achieved	25 Lab technicians from 6 district hospitals and 13 health centers have been trained.
Support districts' annual work planning process	Achieved	15 health center in-charges and 15 health center managers in Kirundo HD trained in annual planning process and 112 participants from 12 IHPB districts trained on district planning, monitoring and evaluation of activities including health information systems.
Improve quarterly coordination meetings	Achieved	IHPB supported and participated to all 48 health district-led quarterly coordination meetings.
Assess and strengthen supervision system	Continuous	IHPB is elaborating an electronic instrument for supervisors to assess and improve performance of FOSAs. A paper-based draft is being pilot-tested.

During the two first years of IHPB, the project designed and conducted a district health office assessment (BDS survey) for the twelve districts supported by the project, with a focus on eleven key management functions of a district. In year 3, IHPB continued to work with provincial and district health offices to progressively strengthen district-level capacity and performance in 4 priority functions related to achieving the project's mandatory results:

- Leadership and governance function;
- Human resource management;
- Supply chain management; and
- Infrastructures and equipment.

From October 2015 to September 2016, IHPB implemented the following key activities:

Identify, reproduce and distribute all current national health policies, protocols, and guidelines needed by FOSAs

To improve document management, IHPB supported the identification, printing/photocopying and distribution of current national health policies documents, protocols, and guidelines needed by health facilities. The distribution of documents is done by IHPB staff and/or national and district counterparts during training sessions and during supervision visits by IHPB staff (PTOs). There are new documents produced by the MOHFA and IHPB continue to provide support in printing/photocopying and distribution

of these new documents. In some health facilities, some health providers consider documents distributed during training sessions as their own documents.

During Year 3, IHPB identified and distributed the following documents:

HIV/AIDS:

- 81 "directives national pour la prise en charge de la Tuberculose et les comorbidités" have been distributed to participants in two five-day training sessions on TB/HIV coinfection management in Kayanza to 81 healthcare providers.
- 55 "module de formation sur le dépistage du VIH intégrant le dépistage à initiative du prestataires" have been distributed to 55 Lab technicians of Kirundo health province during a training session on manipulation of rapid HIV test.

Integration:

- 63 "manuel de reference sur l'integration SR/VIH/PTME" have been distributed to healthcare providers Kayanza health province in charge of HIV services who participated in five-day training session on integration RH/FP/PMTCT and HIV to integrate family planning in HIV/PMTCT services.
- 15 modules used is the national manual on contraceptive technology (MANUEL DE REFERENCE SUR LA FORMATION EN TECHNOLOGIE CONTRACEPTIVE) has been distributed to healthcare providers from Karusi health province in charge of curative consultation for under five children on family planning counselling who participated in five-day training session in order to integrate family planning in curative consultation.
- During the same period, a total of 23 manuals "PROTOCOLE NATIONAL DE PRISE EN CHARGE INTEGRÉE DE LA MALNUTRITION AIGUË (PCIMA)" has been distributed to healthcare providers from Kirundo health district who participated in five-day training session on screening and managing of malnutrition in order to integrate and improve malnutrition screening and care in curative consultation.

Malaria:

- In close coordination with the staff of the National Malaria Control Program (NMCP) and the staff of Information, Education and Communication service (IEC), messages on the importance of SP in IPTp were developed and pre-tested. Thus 3,309 leaflets bearing information (in Kirundi) were produced and distributed to CHWs (3,250: one copy each) and to HPTs (59). To ensure the comprehension and good use of the leaflets, IHPB in coordination with health promotion technicians organized, at communal level, a one-day training-sensitization session across the 12 IHPB districts. A total of 3,250 CHWs (1,285 F and 1,965 M) attended.
- 195 new guidelines of malaria case management distributed during training sessions on new guidelines of malaria case management by health workers in Kayanza, Gahombo, Musema, Kirundo, Mukenke, Busoni, Vumbi, Buhiga and Nyabikere health districts, the new guideline includes treatment of severe malaria using intravenous Arthesunate in pre-referral and Quinine + Clindamycin in case of severe malaria.
- 54 iCCM guidance, 54 livrets de l'ASC and 54 guides du formateur sur iCCM distributed during three 4-day training sessions of 47 health workers on CCM of malaria in Kirundo (17), Gashoho (15) and Gahombo (15) health districts.
- 17 CCM of malaria guidelines distributed during a 4-day training session for an additional health care provider on CCM of malaria in Kirundo health district.

MNCH

- New guidelines of MNCH were distributed (203 manuels de l'Agent de Santé Communautaire pour les 7 pratiques clés) in Nyabikere health district, "le circuit de dispensation du medicament" in the 45 health centers and 3 district hospital of Kayanza health province.
- New guidelines of HIV were also distributed in the Kayanza health facilities ("16 dossiers du patient VIH enfant et adulte" in the 16 health centers of Kayanza health district, in 6 health facilities in Gahombo health district and in 5 health facilities in Musema health district.

IHPB supported the identification, printing/photocopying and distribution of all current national health policies, protocols, and guidelines needed by the FOSAs, and will now transition these responsibilities to district health teams so that they can sustain this management function without the project through the following activities:

- IHPB will share the computerized database of key documents for each one of the four health domains of IHPB with the district teams.
- Jointly with the MOHFA and districts, IHPB will clarify how many of each document needs to be available in each facility per domain and whether these documents are given to staff/health providers or made available to all in a space designated for that in each facility (library).
- When appropriate, districts can use their IKG to provide storage (shelves) to health facilities.
- Needs and gaps will be identified through an inventory conducted during supervision visits.
- Distribution of these documents will be done by health districts teams and themselves (supervisors).

The percentage of supported facilities that have available all current national health policies, protocols, and guidelines has increased significantly and IHPB has already exceeded its contractual target for each of the domains. However, some disparities remain across domains, which are partially explained by the strict criteria used to measure this indicator: all documents must be available for each domain.

Build capacity of 12 supervisors in preventive maintenance for medical equipment

IHPB planned to build capacity of 12 supervisors in preventive maintenance for medical equipment and the trainers were Technicians from ALCHEM and HMS, two suppliers of the equipment. This activity was not achieved because the 12 supervisors were not available over the 12 months when trainers were available to organize and conduct the training.

Train lab technicians of the six district hospitals to perform clinical laboratory tests

In collaboration with health districts offices, IHPB organized a five-day training session of 25 Lab technicians from 6 district hospitals and 13 health centers in Kayanza, Karusi, Kirundo and Muyinga provinces to perform HIV/AIDS screening, dried blood spot (DBS) collection, quality assurance and quality control of medical laboratories, handling and preventive maintenance of CD4 count machines (Facs count and Pima), biological diagnosis of malaria, pulmonary TB, and syphilis, and management of biomedical waste. IHPB has hired 2 lab technicians posted in Kayanza and Kirundo provincial offices who conduct quality assurance of lab activities through supervision visits and on-site continuous training and mentoring as needed, in addition to ensuring the supply of lab reagents.

We noticed improvement of knowledge: all participants passed with more than 50% in posttest whereas the low score in pre-test was 12%. In the meantime, the 2 lab technicians posted in Kayanza and Kirundo provincial offices observed that during formative supervision missions, the lab technicians who participated in the training sessions use well the SIMS tools, focusing on supply chain management system (reagents), HIV laboratory activities and HIV related services delivery.

The number of supported testing facilities with capacity to perform clinical laboratory tests supported with PEPFAR funding has increased to cover all 5 laboratories, hence the LOP target has already been achieved.

Support districts' annual work planning process

According to the annual MPHFA planning that started in October 2015, IHPB staff participated in health district planning sessions so that IHPB-supported activities are included in the work plans of the districts.

With the objective to orient districts for the 2106 planning exercise, on the planning annual process including monitoring and evaluation, in collaboration with Kirundo health district bureau, IHPB organized and conducted a 3-day training session that brought together 15 health center in-charges and 15 health center managers. Also, to reinforce health province and district core teams in planning, in partnership with the MPHFA's Department of Planning, IHPB organized and conducted five-day comprehensive training sessions on district planning, monitoring and evaluation of activities including health information systems in July 2016 (11-15 July) for 112 attendees: heads of provincial bureaus (4), heads of district bureaus (10), hospital directors (10), provincial, district and hospital managers (26), provincial, district and hospital health information managers (22), provincial and district hospital supervisors (29) and field-based IHPB staff (11). IHPB continued to financially support districts to develop their annual work plans through in-kind grants and technically through sharing, analysis and use of IHPB data and district reports for evidence-based planning.

Improve quarterly coordination meetings

IHPB supported all 48 health district-led quarterly coordination meetings through the participation of technical staff (STA/HSS, malaria specialist, the FOM and the M&E Technical officer) and funding from in-kind sub-grants. Health and non-health sector partners participated to these meetings.

During these meetings, IHPB activities for year 3 were presented to participants and many topics relevant to IHPB were discussed: health district planning process, planning of joint supervision, debate community health system matters, including data analysis in the health districts and how to strengthen the community health system [For example how to make provision of kits to CHWs for Community Case Management (CCM) of malaria]; IHPB support in quantification and requisition of HIV commodities for Kirundo et Kayanza health provinces, the planning of joint supervisions, IHPB project facilitation to the transport of samples and results PCR / DBS and Viral Load for analysis from Kayanza and Kirundo health provinces to the Centre de Recherche de Virologie et de Diagnostic Biologique (CRDBi). For all issues, solutions were proposed.

The coordination meetings have been merged with the quarterly data use meeting supported by IHPB in order to focus on decisions based on the analysis of data.

During Year 3, with coordination meetings, IHPB has met goals to integrate planned activities in health district's annual plan, to implement these activities collaboratively, and report on progress on activities, results and discuss implementation issues. The usefulness of these meetings is that IHPB discusses with partners on which strategies can contribute to get the expected results.
In Year 4, IHPB will continue to support these coordination meetings but will begin their evaluation with a focus on their effectiveness against standards such as attendance; time management; realistic agenda distributed to all before; appropriate logistics; decisions made on data; and implementation of decisions from previous meeting.

The percentage of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis remains at 100%: all districts conduct their annual planning (a requirement of the MPHFA) and IHPB or other partners support quarterly coordination meetings.

Assess and strengthen supervision system

IHPB contributed to strengthen the supervision system, through logistical, financial and technical support. During joint supervision visits with district supervisors, IHPB observed that there is little preparation for supervision visits or efforts to focus visits on priority issues of the FOSA related to IHPB related mandatory

results. In addition, the issue remains of the availability of district supervisors, which leads to various levels of joint supervisions happening as planned. IHPB has a developed a draft paper based of an integrated instrument for improvement and capacity strengthening that is being piloted before being transformed into an electronic tablet-based version for supervisors. The tool will help IHPB and district supervisors assess and improve the performance of FOSA against IHPB results.

The percentage of supported facilities that receive supportive supervision on a regular basis dropped in 2015 due to the political situation in the country. This indicator measures only the supervision visits conducted by the district supervisors (not the IHPB staff) and is extracted from the GESIS/DHIS2 databases. The FY2016 results will be available after midterm evaluation.

Progress and discussion on the HSS (Sub CLIN 3.1) results indicators

Indicators	**Target FY2016**	**Achieved FY 2016**				**%**
		October-December	**Jan-March**	**April-June**	**July-September**	
3.1.1 Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]	FP/RH: 30% ANC: 50% MH: 50% CH: 30% HIV: 50% Malaria: 89% GBV: 30%	NA	NA	NA	NA	• FP/RH: 24.4% • ANC: 38% • MH: 49% • CH: 27% • HIV: NA • Malaria: 98% • GBV:33%
3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result]	29.6%	NA	NA	NA	NA	51.1%
3.1.3 Number of supported testing facilities with capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	80% (4/5)	100%	100%	100%	100%	100%
3.1.4 (previously 2.2.4 in PIRS) Percent of supported facilities that receive supportive supervision on a regular basis [Mandatory Result]	100%	-	-	-	-	78% (135/164)
3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]	100%	100%	100%	00%	Actual: 100%[4]	100%

[4] All the 12 health districts and provinces are supported to conduct annual planning and quarterly resource coordination meetings

3.1.1 Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]

To inform progress made in Y3, IHPB conducted an active data collection was conducted. Results showed that most of supported facilities reached a good achievement of expected results on availability of current national health policies, protocols, and guidelines:

- Family Planning/Reproductive Health (FP/RH): with Y3 target set at 30%, 24.4% (80%);
- Ante Natal Care (ANC): with Y3 target set at 50%, 38% (76%);
- Maternal Health (MH), with Y3 target set at 50%, 49% (98%);
- Child Health (CH): with Y3 target set 30% 27% (89%).
- Malaria: with Y3 target set at 89%, 98% (110%)
- Gender Based Violence (GBV): with Y3 target set at 30%, 33% (111%)
- As for HIV/AIDS tools, with Y3 target set at 50%, data was still being analyzed by the time of report submission.

3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result]

With the Y3 target set at 29.6%, it was found 51.1% (172% had the required equipment. There has been no change for laboratories, explained by the lack of equipment that was supposed to be delivered by another program in charge of supplying microscopes.

3.1.3 Number of supported testing facilities with capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]

After the refocus of PEPFAR 3.0 on two provinces, the number of supported testing facilities with capacity to perform clinical laboratory tests supported with PEPFAR funding has decreased from 9 to 5. All five facilities have the capacity to perform clinical laboratory testing.

2.2.4 Percent of supported facilities that receive supportive supervision on a regular basis [Mandatory Result]

Though the target set for Y3 was 100%, 78% (135/164) facilities received supportive supervision on a regular basis.

3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]

The percentage of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis remains at 100% i.e. 12 IHPB districts, with support from the IHPB, conduct their annual planning (a requirement of the MPHFA) including quarterly coordination meetings

Sub-CLIN 3.2: Strengthened M&E and data management systems at facility and community levels

Planned for Y3	Achievements and results	Comments
Organize a five-day session to train 95 health providers on HIV data collection and reporting using updated tools	Partially achieved	Trained 82 (86.3%) out of 95 planned 13 district staff not available due to agenda conflict
Train 345 CHWs on standardized reporting tools to initiate and improve reporting of community-driven data	Achieved 994 (288.1%)	994 trained (200 in Vumbi and 794 in Gashoho)
Conduct one DQA per facility-174 DQAs completed	Partially achieved	Completed 35 (20.1%) DQAs out of 174 planned Due to multiple conflicts of agenda, this activity could not be fully completed.
Organize a five-day session to train 79 BPS and BDS staff in data demand and use	Achieved	112 trained - in a more comprehensive training jointly organized with HSS team, in partnership with the Department of Planning, MPHFA
Strengthen capacity of district teams and facility managers on use data through quarterly district data analysis workshops - 36 workshops organized	Partially achieved	12 (33.3%) data analysis workshops organized out of 36 planned. Supported districts could not organize all the planned workshops, again due to conflict of agenda
Develop and disseminate data visualization dashboards for use at the facility level - 80% of facilities (139) have data visualization dashboards	Partially achieved	- 110 (79%) have dashboards. IHPB could only visit 110 facilities during the reporting period
Develop improved FSW follow-up database and update reporting form	Cancelled	The FSW cohort was in Muyinga but PEPFAR withdrew from that province starting FY 2016

Within Y3, IHPB undertook a number of steps to improve data quality, the data demand and use at the community, facility and district levels. In addition, activities were planned and implemented to realize, in partnership with the national health information system at the central, provincial, district and facility levels, where appropriate, to ensure that the data collection tools for the supported health zones are available on service delivery sites in the provinces of discussion.

Organize a five-day session to train 95 health providers on HIV data collection and reporting using updated tools

In the framework of M&E strengthening, IHPB conducted two five-day training sessions, one in Kayanza another in Kirundo during the first quarter of fiscal year. The training subject was the use of HIV-related tools data collection and reporting tools recently updated by the National Program for AIDS/STIs Control (NPAC). The purpose of the training was to improve the quality of HIV-related data especially in matters of accuracy and completeness. Target audience was made of provincial and health district HIV focal points and supervisors, the in-charges of health centers and head-nurses of HIV care units in supported hospitals. In all, out of 95 targeted for the training, 82 health providers (56 males and 26 females) were trained during the reporting period, 55 in Kayanza and 27 in Kirundo.

Train 345 CHWs on standardized reporting tools to initiate and improve reporting of community-driven data

IHPB used a provincial workshop on community health activities to raise interest of 81 attendees on the use of the standard community health reporting tool. Participants included health promotion technicians and in-charges of health centers called to contribute to the training and mentoring of community health workers on the use of the aforementioned tool.

As it has not been possible to train Community Health Workers (CHW) on the use of standard reporting tool during quarter January-March 2016 due to conflicts of agenda, IHPB successfully conducted that activity during Y3 and results exceeded expectations. For 345 CHW targeted, 994 CHWs (577 males and 417 females) were trained on the use of standard reporting tool (GASC) including 200 from Vumbi district and 794 from Gashoho district. The topic was either included as a module in another training (Vumbi) or conducted as a one-day training, taking opportunity of planned CHW monthly meetings (Gashoho). A refresher training on the use of the Groupement d'Agents de Santé communautaire (GASC) tool was also conducted to 590 other CHWs of Kayanza (329) and Gahombo (261) HDs.

Conduct one DQA per facility

Routine data quality assessments are conducted during field supervisions. Such exercises help health providers to better understand variables and indicators included in data collection and reporting tools to contributes to the quality improvement of their reported data.

Throughout the reporting period, for 174 targeted IHPB conducted routine data quality assessments (DQAs) in 42 health facilities, ie 24% (6 during quarter one, 27 during quarter two and 7 in quarter four). Obviously, conflict agenda for other diverse activities did not allow regular DQA exercises to complete the expected result.

The major constraint observed and repeatedly reported is the stock-out of standardized registers, especially in the MNCH area. As it is usually the role of the National Health Information Department to make data collection tools available country-wide, IHPB was not required to support that area. However, as standardized tools play a critical role in data quality, IHPB created an inventory of needs and introduced to USAID a request for concurrence in order to, at least temporarily, contribute to the availability of those tools.

Organize a five-day session to train 79 BPS and BDS staff on data demand and use

In 2016, IHPB planned to train cadres of provincial and district health management teams on data demand and use. As there were needs of training on health district management for the same team in general, IHPB partnered with Department of Planning (MPHFA) to organize a comprehensive five-day training of BPS and BDS cadres. Topics included modules on district management and work planning, modules on monitoring and evaluation, Health information system management as well as data demand and use. In all, for 79 targeted, 112 (95 males and 17 females) attended the training. Participants included – 4 heads of provincial bureaus; 10 heads of district bureaus; 10 hospital directors; 26 provincial, district and hospital managers; 22 provincial, district and hospital health information managers; 29 provincial and district supervisors; and 11 field-based IHPB staff.

Strengthen capacity of district teams and facility managers on data use through quarterly district data analysis workshops

In order to strengthen capacity of district teams and facility managers on data use IHPB supports quarterly data review workshops at the district level, through in-kind grants. They bring together the health district team, all health promotion technicians and in-charges of health centers located in the district catchment area, along with other partners interested in data quality and use. The workshops offer opportunity to present data from all facilities and analyze progress made in matters of achievement and quality. As they are normally one-day workshops, all data are not discussed but agenda are jointly prepared based on issues previously observed during supervisions. During those workshops, IHPB staff took the opportunity to discuss observations made during routine DQA exercises and suggestions for improvements, not only for data quality but also for service uptake. As the project supports also quarterly coordination meetings, starting quarter four, IHPB recommended coordination so that coordination workshops immediately follow the data review meetings in order to improve effectiveness and enrich coordination meetings with data review findings.

During the annual period, 16 data review workshops were organized (2 in Q1, 3 in Q2, 7 in Q3 and 4 in Q4) out of 32 targeted, i.e. 50 of achievement. Although, the project is always ready to support those events, conflicts of agenda hindered district authorities from organizing those workshops on a regular basis.

Develop and disseminate data visualization dashboards for use at the facility level

This activity should be conducted routinely and 80% of facilities were targeted to have updated data visualization dashboards. For multiple agenda conflicts, a situational assessment of needs was only conducted during the second quarter (March 2016) in 110 health facilities (44 in Muyinga, 40 in Kayanza, 16 in Karusi, and 10 in Kirundo). Globally, although some facilities were having displayed data visualization dashboards, they were not updated, as they are no longer required by health authorities, according to interviewed health providers. Thereafter, IHPB M&E technical officers worked on building the capacity and interest of health providers on the use of dashboards to track facility-level performance.

However, one of the findings from field visits during the period under review is that some health facilities still do not update them regularly and a number of health providers were not able to fill them. During Y4, efforts will continue to be made for improvement.

Develop improved Female Sex Worker (FSW) follow-up database and update reporting form

For its FY 2015 COP, PEPFAR Burundi placed Muyinga Province as non-priority zone and withdrew IHPB support to HIV activities in that province. Thus, development of the database was cancelled as the sub-grant supporting FSW was closed with December 2015.

Other routine M&E activities

Within the year under review, IHPB supported additional M&E strengthening activities:

(a) Conducted supportive supervisions and active data collection in 171 health facilities (Karusi: 35, Kayanza: 42, Kirundo: 46, and Muyinga: 48) on IPTp activities to inform progress made after health providers were trained on IPTp - IPTp data is not yet included and collected in the routine health information system.

(b) At the request of the Muyinga Health District, IHPB supported the training of 21 health providers as M&E focal points in their respective health facilities in order to lessen the workload of in-charges on activity and data reporting.
(c) In partnership with Muyinga health authorities, IHPB supported a workshop attended by provincial and district health teams, all health facility in-charges, and health promotion technicians on the coordination of community health activities.
(d) Due to data quality issues inherent to manual aggregation of community case management of malaria reports, IHPB developed a database to facilitate data aggregation and installed it on project computers. If the new database is found to be efficient, IHPB will propose it to health districts as part of community HIS strengthening**.**
(e) In order to increase use of project generated data at the intermediate and peripheral level, IHPB conducted a workshop in Karusi (July 21, 2016) to share findings of two surveys conducted by the project, especially SARA and Household Surveys. Participants include cadres for the provincial and both district health bureaus (Buhiga and Nyabikere), Buhiga and Karusi hospitals cadres and representatives from all operational health centers, totaling 53 attendees.

Progress and discussion on the **M&E and data management results and indicators**

Indicator	**Y3 target**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Result**
3.2.1 Percent of facilities that maintain timely reporting [Mandatory result]	97.8%	100%	100%	100%	100%	100%
3.2.2 Percent of districts and facilities that demonstrably use facility- and community-level data for timely decision making [Mandatory result]	Facility: 90% District: 80%					Facility: 94%; District: 89%

There are two IHPB contractual indicators related to M&E area:

Percent of facilities that maintain timely reporting:
This indicator already had a good baseline. Thanks to the Performance-based financing mechanism, achievement is consistently good and IHPB works to maintain this performance.

Percent of provinces, districts and facilities that demonstrably use facility- and community-level data for timely decision making:
In order to inform progress made on this indicator, in October 2016, IHPB conducted an active data collection which showed improvements in both facility and district levels of data use for decision making i.e. from 90 to 94% (107%) for facility and from 80 to 89% (111%) for districts.

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated Services

Planned for Y3	Achievement and Results	Comments
Provide support to CSOs for improving management systems, including financial management and human resources management, through at least quarterly visits.	Achieved	IHPB staff provided support to ANSS and RBP+ administrative and financial staff at a quarterly basis
Conduct quarterly joint supportive supervisions focused on technical activities.	Achieved	IHPB staff in collaboration with the antenna coordinators, conducted quarterly supportive supervision to ANSS and RBP+ field staff in Kirundo province
Conduct trainings following PEPFAR assessments with SIMS tool.	Canceled	After PEPFAR assessment, improvement plan was set up, but there was no need for formal training
Conduct a 5-day training on the integration of RH/HIV/PMTCT services for health providers from ANSS' Kirundo and Ruhehe health center.	Achieved	5 health providers were trained
Conduct a 5-day training on national malaria guidelines and IPTp for health providers from ANSS' Kirundo and Ruhehe health center.	Achieved	4 health providers were trained
Conduct a 5-day training on sexually transmitted infections for health providers from ANSS' Kirundo clinic.	Achieved	4 health providers were trained
Support CSOs to ensure compliance with VAT requirements.	Achieved	VAT claimed but not yet reimbursed
Reassess CSO capacity using IDF tool: three 3-day assessment sessions for 3 CSOs (20 people per CSO).	Achieved	3 CSOs assessed for measuring progress made after 14 months of capacity building
Assess CSOs against criteria for graduation.	Achieved	3 CSOs assessed for graduation

The project's aim is for CSOs to become direct recipients of donor funding and maintain quality services without intensive external technical assistance. Therefore, ownership of capacity building process is crucial for achieving this goal. During this year 3, a variety of approaches, techniques and strategies to strengthen capacities of local organizations including trainings, coaching, assessments and supervisions have been used. Following activities have been achieved:

Provide support to CSOs in improving management systems, including financial management, and human resources management through at least quarterly visits.

For improving management systems, including financial management and human resources management, IHPB staff from the finance team conducted supportive supervisions in the Kirundo branches of ANSS and RBP+. These supervisions aimed to improve the skills and practice for staff involved in administration and finance. At RBP+ and ANSS clinics in Kirundo all the documents related to policies and procedures, financial reports and human resources management were in place, comprehensive and well completed. The marking and branding implementation has been progressively improved as well through the capacity building visits. The security of funds, particularly in ANSS has been improved thanks to advice and supervisions from IHPB staff; ANSS opted to use checks and bank transfers more often than cash. After each visit a list of recommendations was developed and shared in response to any weaknesses noted and followed up on during the next visit.

Conduct quarterly joint supportive supervisions focused on technical activities.

In October 2015, USAID team with IHPB staff and health district staff conducted a joint supervision focused on HIV/AIDS activities in ANSS' Kirundo clinic using the SIMS tool[5] for health facilities. An improvement plan based on the observed weaknesses found was developed and a quarterly supervision visit was conducted for measuring the progress made. ANSS Kirundo implemented all recommendations formulated by the evaluation team.

Other supervisions focused on the progress toward completing activities outlined in the subcontract signed with FHI 360, nearly all of which were achieved. They include HIV testing and counseling, ARV and cotrimoxazole treatment, HIV prevention, integration of malaria, FP, MCH, tuberculosis, treatment for non-communicable diseases; trainings on various topics (integrating HR/HIV/PMTCT, IST, national malaria guidelines and Intermittent Preventive Treatment during pregnancy IPTp) and supervisions. The targets were successfully achieved except those related to MSM activities. MSMs are not identified and don't have a focal point for discussing with the ANSS clinic team. During quarter 4 (July-September 2016), ANSS Kirundo conducted an outreach activity of sensitizing FSW, condom distributions and screening of FSW, 44 FSW were screened with 5 among them testing HIV positive.

RBP+'s project supports the OVC in many aspects as health, education, judicial issues, and nutritional advice. All targets outlined in the subcontract signed with FHI 360 have been achieved. The RBP+ activities related to HIV/AIDS were also assessed using the Community SIMS tool. The recommendations from the assessment have been formulated and an improvement plan was developed. Quarterly, IHPB staff monitored the implementation and report that all activities were successfully completed.

Conduct trainings following PEPFAR assessments with SIMS tool.

IHPB had planned to conduct trainings following the PEPFAR assessments with SIMS tool, but in the improvement plans that were developed, trainings were not necessary. IHPB staff conducted supportive supervisions, in which coaching techniques were applied.

Conduct 5-day training on the integration of RH/HIV/PMTCT services for health providers from ANSS' Kirundo and Ruhehe centers

The objective of this training was to strengthen the capacity of health care providers and health district supervisors to integrate Reproductive health, HIV and PMTCT services in order to improve overall quality in the Kirundo province health centers. Five health providers from the ANSS clinic (3 persons) and Ruhehe health center (2 persons) were trained during a 5-day session. Participants were trained on the following topics: reproductive health generalities, basic topics on HIV and PMTCT; National Protocol for ARV treatment in Burundi; universal precautions and creating a safe workplace; handling and processing equipment and medical instruments; support for blood exposure accidents and other body fluids; Supportive Care to caregivers; information and counseling before HIV testing; HIV testing and counseling for RH/HIV/PMTCT; Concept of focused ANC; support for common health problems during pregnancy; prescription preventive care; support for Labor and childbirth; and care of the mother after childbirth and newborn during the first hour.

[5] SIMS: Site Improvement Monitoring Systems

Conduct 5-day training on national malaria guidelines and IPTp for health providers from ANSS' Kirundo and Ruhehe health center

IHPB conducted training on management of uncomplicated and severe malaria in Burundi's health facilities for 4 ANSS health staff involved in medical care—3 nurses and 1 laboratory assistant. The results achieved included an improvement of knowledge on the clinical diagnosis of malaria, the treatment of severe and uncomplicated cases of malaria, handling and interpretation of RDT and ways of preventing malaria. An additional health provider was trained on intermittent preventive treatment of malaria during pregnancy (IPTp). Even in the absence of antenatal care service at Kirundo, the health provider will better manage the few cases of pregnant women it handles.

Conduct 5-day training on sexually transmitted infections for health providers from ANSS' Kirundo clinic

In addition to the planned trainings, IHPB provided financial and technical support for conducting a 5-day training on sexually transmitted infections for health providers from ANSS' Kirundo clinic. The objective of the training was to enhance the skills of the ANSS health providers to enable them to properly fulfill their role in syndromic management of sexually transmitted infections. The training was organized for the four antenna nurses. At the end of the training, participants have improved knowledge and skills in the syndromic management of sexual transmitted infections, the use of algorithms, education and counseling the patient, the partner care and data collection.

Support CSOs to ensure compliance with VAT requirements

Organizations implementing development projects funded by the U.S. government are exempted from certain taxes (including the Value Added Tax) imposed by the Government of Burundi and exemptions cover both the principal recipients and sub-recipients. Claiming VAT refund for any invoice equal or greater to $500 is mandatory. RBP+ documented and claimed the VAT paid but the Burundi Revenue Authority has not yet reimbursed. ANSS has not yet made its claim for VAT refund because it did not have any eligible invoices for VAT reimbursement.

Reassess CSO capacity using IDF tool: three 3-day assessment sessions for 3 CSOs (20 people per CSO)

IHPB conducted three separate 3-day capacity assessment workshops that focused on organizational and technical domains for each of the three IHPB partner CSOs involving a total of 58 participants: ANSS (20), RBP+ (18) and SWAA - Burundi (20). The assessment, which was adapted from the Institutional Development Framework tool, aimed at measuring the progress the three CSOs have made after 14 months of IHPB and PMTCT Acceleration Project support. Early analysis indicates that the scores have significantly improved compared to the scores of the baseline capacity assessments conducted in July/August 2015.

Each CSO was scored from 1 to 4 and it is estimated that any score superior or equal to 2 two is good and the table below shows the comparison of the scores obtained in the 2 sessions.

Organizational and Technical Capacity Scores

Organizational Domains						
	ANSS		RBP+		SWAA Burundi	
	July 2014	**November 2015**	August 2014	**November 2015**	July 2014	**November 2015**
Oversight/Vision	2.46	**2.85**	2.63	**2.98**	2.88	**3.23**
Management Resources	2.76	**3.09**	3.35	**3.67**	2.79	**3.18**
Human Resources	2.54	**2.97**	2.79	**3.47**	2.21	**3.17**
Financial Resources	2.76	**3.00**	2.81	**3.26**	2.69	**2.94**
External Resources	2.25	**3.08**	3.08	**3.83**	2.71	**3.27**
Technical Domains						
	ANSS		RBP+		SWAA Burundi	
	July 2014	**November 2015**	August 2014	**November 2015**	July 2014	**November 2015**
HIV AIDS Care and Treatment	1.78	**2.84**	NA	**NA**	1.98	**2.81**
Family Planning	2.45	**2.90**	NA	**NA**	2.40	**3.13**
Maternal, Newborn, and Child Health	NA	**NA**	NA	**NA**	NA	**NA**
Prevention of Mother to Child Transmission of HIV	2.14	**2.64**	NA	**NA**	2.14	**3.04**
Malaria	1.00	**2.21**	NA	**NA**	1.50	**2.04**
Advocacy and Community Mobilization	1.17	**3.00**	2.17	**2.83**	1.25	**2.00**
Most At-Risk Populations (MARPS)	2.00	**3.00**	2.38	**2.75**	1.75	**2.38**

Thanks mainly to the support provided by IHPB and PMTCT projects, significant progress have been made in both the organizational and technical domains.

Previously, in September 2015, the CSOs had been assessed with the NUPAS tool in order to determine whether the organization has sufficient financial and managerial capacity to manage USAID funds in accordance with U.S. Government and USAID requirements. With the NUPAS tool, the CSOs are classified based on the overall score per criterion as followed: 1.0 – 1.5 Inadequate; 1.51 – 2.5 Weak; 2.51 – 3.5 Adequate; 3.51 – 4.0 Strong

The scores obtained per criterion in this assessment are presented in the table below:

	ANSS	**RBP+**	**SWAA Burundi**
Criterion	Average score/4	Average score/4	Average score/4
Legal Structure	3.50	3.60	3.60
Financial Management and Internal Control Systems	3.34	3.22	2.78
Procurement Systems	4.00	3.81	3.13
Human Resources Systems	3.73	3.71	3.52
Project Performance Management	2.63	3.13	2.38
Organization Sustainability	3.09	3.47	2.94
Overall Score	**3.38**	**3.49**	**3.06**

The NUPAS tool was used as part of a "mock" assessment, mimicking the procedure that USAID would follow in order to assess a non-US organization's financial and administrative systems prior to signing an award. Through this exercise IHPB's CSO partners gain the experience of preparing for and participating in an assessment of this type and a better understanding of USAID's minimum requirements, while IHPB was able to gather additional data and gain further insight into a CSO partner's readiness for direct USAID funding. Based on the scores obtained, the three CSOs appear capable of passing a USAID-administered NUPAS. The results suggest no major deficiencies or weaknesses, though it does highlight some areas for continued attention and/or improvement.

Assess CSOs against criteria for graduation

The Local Partner Transition Report presents the methodology used for assessing the CSOs, the criteria required for transition and the findings and recommendations for each CSO. By drawing from the results of organizational and technical capacity assessments, evaluating performance in the implementation of IHPB sub-awards and performing a final assessment based on USAID's Non-U.S. Organization Pre-Award Survey (NUPAS) tool, IHPB has made comprehensive recommendations to USAID about how to move forward with direct funding for its three transitioning organizations. Each assessment has been conducted in three phases:

1. Desk review: IHPB conducts an assessment of the candidate's legal documentation, guidelines, manuals and other tools and analyzes the assessments as part of the Organizational and Technical Capacity Assessment. These include both self-assessments and the assessment utilizing the NUPAS tool.
2. Site visits, consultations and staff reports. The information gathered in the desk review is complemented by a site visit and observations of the IHPB staff members who work most directly with the partners.
3. Comprehensive analysis. The assessment team compares its findings to the criteria to decide whether an organization should be recommended for advancement.

As part of the IHPB project, six local partner transition criteria[6] were developed and regularly monitored. The 3 CSOs assessed in 2015—ANSS, RBP+ and SWAA Burundi—meet all the requirements of the six criteria. IHPB considers these 3 organizations to be among the leading health-focused CSOs in Burundi and, based on the evaluation results, recommended each of them to USAID for direct funding.

Sign new amendment with ANSS

During this period, in order to accelerate IHPB achievements in HIV activities, the project initiated procedures with both USAID and FHI 360 (HQ) in order to maintain ANNS as a partner for the remaining life of project by carrying out a modification aimed at (1) increasing the SOW, (2) extending the period of performance, and (3) increasing estimated and obligated budgets. The Contracting Officer's Representative provided concurrence and FHI 360 made the necessary review. The amendment was signed by both FHI

[6] (1) The CSO must meet the law requirements and be recognize by the government, (2) The organization must demonstrate a clear separation of governance and executive functions, (3) the organization must be in good standing with FHI 360, (4) The organization must have a well-established accountability and policy framework, (5) The organization must have a well-established accountability and policy framework, (6) The organization should demonstrate basic proficiency in areas necessary for successful management of USAID cooperative agreements for transition

360 and ANSS. The new SOW focuses on HIV services integration and key populations (MSM, FSW) in areas with high risk of HIV infection in Kirundo province. It starts on July 1, 2016 and ends September 30, 2018.

Progress and discussion on the CSO results and indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec	Jan-Marc	April-June	July-Sept	Total
Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas [MR]	4	3	2	2	2	**3**
Number of CSOs that transition (graduate) and qualify to receive direct USAID funding [MR]	3	0	3	3	3	**3**
Number of CSOs that improved their organizational capacity with USG assistance (using IDF tool)	4	3	3	3	3	**3**

Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas

In July and August 2014, IHPB facilitated a process of self-assessment with each CSO partner that utilized a tool adapted from the Institutional Development Framework (IDF). This tool allows participating CSOs to conceptualize their current technical and organizational capacity along a continuum, set goals for future performance and plan for the activities and resources necessary for their continued growth and development. A key output of the self-assessment is an Institutional Improvement Plan (IIP). IHPB's signature approach pairs grants with customized resources and technical assistance aligned with the CSO IIPs and project implementation. In November 2015, IHBP facilitated a process to reapply the self-assessments to gauge progress and reflect on changes in capacity. The CSOs assessed demonstrated improvement in both technical and organizational domains as showed in the previous result tables.

Number of CSOs that transition (graduate) and qualify to receive direct USAID funding

Based on firsthand experience of past performance and the results of the local partner transition assessment, the IHPB team selected three organizations to evaluate for transition to direct USAID funding—ANSS, RBP+ and SWAA Burundi. In several regards, IHPB considers these organizations to be among the leading health-focused CSOs in Burundi and, based on the evaluation results (aforementioned), recommends each of them to USAID for direct funding. IHPB submitted in March 2016 the Local Partner Transition report in which it proposed that the 3 CSOs would graduate to direct USAID funding.

Number of CSOs that improved their organizational capacity with USG assistance (using IDF tool)

Using the IDF tool, the 3 CSOs were assessed at the beginning of project implementation in July and August 2014 to determine the performance baseline and in November 2015 to measure the progress made. Through the two cycles of assessment, IHPB was able to conclude that the CSOs have improved their organizational and technical capacity.

Priority He++alth Domain Strategies

Maternal and Newborn Health Strategy

Planned for Y 3	Achievement and results	Comments
Conduct formative supervision for BEmONC	Partially achieved	Only 15 health facilities supervised out of 43 due to non-availability of national trainers. IHPB will train a pool of trainers from the four IHPB provinces
Elaborate and validate tools for maternal death audit	Achieved	Activity conducted in partnership with partners (UNFPA, WHO, JICA and HEALTHNET TPO)
Support Maternal death audits in 9 hospitals	Achieved	29 Maternal death audits sessions conducted Postpartum hemorrhage, infections and malaria were main causes of death
Train 30 providers from Muyinga on BEmOC	Achieved	2 health providers trained per health facility
Train 45 health providers and health district supervisors on EONC	Achieved	9 health workers in Muyinga and 6 in Karusi trained as trainers

The rate of maternal mortality is still high in Burundi at 499 maternal deaths per 100,000 live births. To further enhance Burundi's health system capacity and reduce maternal and neonatal mortality, IHPB proposed Y3 activities which aimed to strengthen provider capacity to deliver MNH services and increase access to and use of essential MNH commodities and services. All activities were implemented in partnership with the national program of reproductive health (PNSR) and key Y3 achievements include:

Conducted formative supervision for BEmONC

After training conducted for 15 HF from Muyinga, as required by the PNSR, IHPB organized a post-training supervision where national trainers went to see how BEmONC services are provided. A total of 15 health facilities were supervised (5 in Muyinga HD: Rugongo, kibimba, Gitaramuka, murama and rugari; 5 in Giteranyi HD: kamaramagambo, Buhorana, Kinyami, Tura and Ruzo, and 5 in Gashoho HD: Mirwa, Gisabazuba, Nyungu, Rusimbuko, Kizi). A total number of 22 health providers trained out of 30 benefited from the supervision. The competency of health providers assessed show that the average was 75%.

IHPB also conducted supervisions for various health areas. In Muyinga, a total of 33 health facilities were supervised during integrated supervisions. The supervisions focused on gender based violence (GBV) and the active management of the third stage of labor (AMTSL). In Karusi, 9 health centers from Buhiga health district were supervised focusing on AMTSL especially on how to collect data on the use of uterotonic to prevent post-partum hemorrhage.

Organized two six-day training sessions on Basic Emergency Obstetric and Neonatal Care (BEmONC) for 30 health providers from Muyinga

In collaboration with PNSR, IHPB organized two six-day training sessions on BEmONC for 30 health care providers (11 males and 4 females) from Muyinga. Training was conducted in Bujumbura at the National Institute of Public Health (INSP) and consisted of strengthening health providers' capacity at offering quality emergency obstetric care in their facilities. Seven signal interventions for BEmONC are defined and must be available to all women giving birth in order to address major causes of maternal and newborn mortality:

(1) parenteral treatment of infection (antibiotics); (2) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants); (3) parenteral prevention and treatment of postpartum hemorrhage (uterotonic); (4) manual vacuum aspiration of retained products of conception; (5) vacuum assisted delivery; (6) manual removal of the placenta; and (7) newborn resuscitation. During the training, four different topics are addressed simultaneously at four stations for three or four participants per station. In each station, a trainer makes an initial assessment before his demonstration. This is followed by practice by the participants and a mid-course evaluation. Participants then move to another station; participants must attend all stations (an average of four stations are run per day).

Each training session includes:

- In-service trainings, which include best practices in the management of labor, demonstration of key interventions on anatomic models, and case studies;
- Acquisition of competencies session where learners use a standardized checklist to become competent in specific skills. Each learner is assessed for competency and anyone who does not succeed in a skill must continue to practice until they are competent. For each training session, participant knowledge and competencies are assessed three times: at the beginning via a pre-test, during the training using a mid-evaluation test, and at the end of the session via a post-test.
- Knowledge and competencies in different topics improved significantly. Assessments found that participants showed great progress in acquiring competencies at the different stations. For the first session on shoulder dystocia management, competencies increased from 1.7% at pre-test to 94% at post-test. Competence on the management of twin delivery increased from 0% at the beginning to 94% at the end. The average in all topics grew over 80%. Competence in all topics was under 30%, with some scoring 0%: shoulder dystocia, the twin delivery, and use of the suction cup.

Organized two six-day training sessions on essential obstetric and neonatal care (EONC) for 30 health providers: In collaboration with PNSR, IHPB organized two six-day training sessions on *EONC* for 30 health care providers from Karusi (5) and Kirundo (25). Trainings were conducted in Gitega. The aim of the trainings was to strengthen health care providers' capacity in offering a quality continuum of services before, during, and after pregnancy. During the first two days, participants attended theory-based sessions on topics such as antenatal care, safe delivery and postnatal care. This was followed by four days of practical sessions using a standardized checklist that measured competence in offering services during the three periods: antenatal, delivery, and postnatal. During this hands-on part of the training, three stations were established: one for antenatal services (antenatal care and PMTCT); one for safe delivery (delivery, active management of the third stage of labor (AMTSL), and newborn resuscitation); and one for post-natal services (episiotomy, mother resuscitation, and postnatal services). At each station, participant knowledge and competencies were assessed three times: at the beginning via a pre-test, during the training using a mid-evaluation test, and at the end of the session by a post-test.
For the first session, there was an average increase in competencies from under 35% to over 85% in all stations. Knowledge increased from 67% to 84%. During the second session of the training, competencies were raised from 30% up to 70%; knowledge increased from 57% to 86%.

Organized three three-day training sessions on active management of the third stage of labor (AMTSL): In collaboration with respective health district bureaus, IHPB organized three three-day training sessions for 61 (36 males and 25 females) health workers from Gahombo (39) and Musema (22) on active management of the third stage of labor (AMTSL). These trainings were conducted following supervisions conducted last

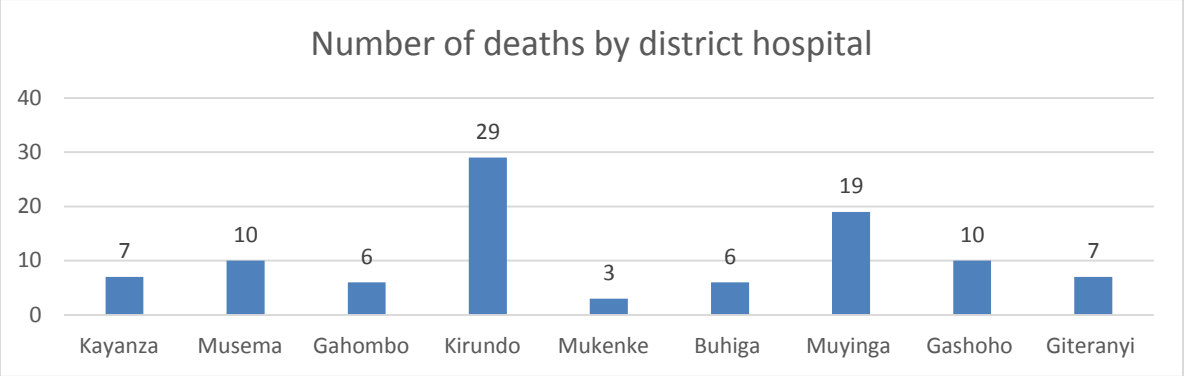
quarter from which we found that there was a need of strengthening capacity of health providers on MCH related topics including Active Monitoring of the Third Stage of Labor (AMTSL).

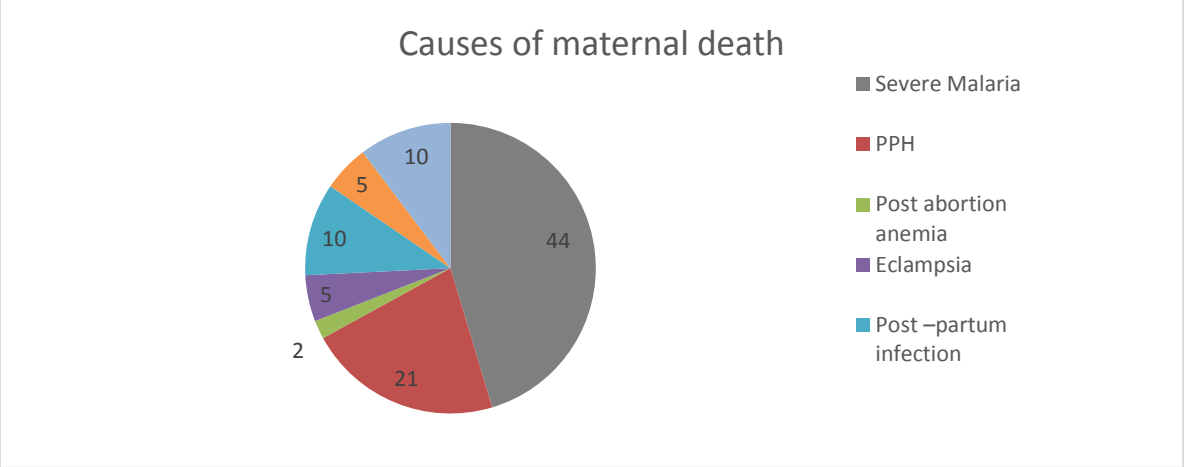
Organized ten-days training of trainer's session on Essential obstetric and neonatal care (EONC) for 15 health providers: In collaboration with PNSR, IHPB organized a ten-day training of trainer's session on *EONC* for 15 people (14 males and 1 females) from Karusi (6) and Muyinga (9). Trainings were conducted in Gitega with the aim to strengthen health district staff capacity as trainers and supervisors of EONC activities. The session was organized in three parts; (1) participants completed a series of theoretical topics (in class) related to antenatal care, safe delivery and postnatal care for two days. (2) Four days of practical sessions took place, using a standardized checklist to promote competencies in offering high-quality perinatal services. Three stations were established where participant knowledge and competencies were assessed three times: at the beginning by a pre-test, during the training using a mid-evaluation test and at the end of the session by a post test. The first station assessed skills providing antenatal services, including PMTCT. The second station assessed safe delivery, including the active management of the third stage of labor (AMTSL), administering uterotonic, and newborn resuscitation. The third station was to assess participant competencies to provide post-natal services with a focus on episiotomy and mother resuscitation (3) After the station-based knowledge and competency, participants returned to their facilities to apply their skills for 2 days. In addition, they practiced training other facility staff on the aforementioned topics for 2 days. The average increase in individual participant knowledge from 57% up to 87%; the average score in demonstrated competencies to offer EONC services increased from under 30% to over 70% in all perinatal care stations. In terms of participants' measured competency to train others, the average score was 87.2% for theory training and 88.2% for practical training competencies using standard National Program of Reproductive Health (PNSR) tool which is part of the training.

Participated in regional workshop on maternal death surveillance: The workshops were organized by region and IHPB participated in the ones held in Muyinga and Ngozi. All the provinces expressed the need for improved maternal death surveillance and the necessity of conducting audit for any maternal death within 30 days of the occurrence. IHPB currently supports maternal death audits in the 4 provinces.

Elaborated and validated tools for maternal death audit: in the process of elaborating data collection tool for maternal death, IHPB contributed to the adaptation of the existing WHO tool to the Burundi context. After adaptation, PNSR and its partners worked together to operationalize the use of the new tool. Activity was coordinated between 5 main partners: World Health Organization (WHO), United Nation Population Fund (UNFPA), Integrated Health Project in Burundi (IHPB), Japanese International Cooperation Agency (JICA) and HealthNet TPO, an international NGO supported by Netherlands Cooperation. IHPB provided financial support to a workshop for orientation on the use of the tool.

Supported Maternal death audits in 9 hospitals: The rate of maternal mortality is still high in Burundi at 499 maternal deaths per 100,000 live births. Despite progress in recent decades, Burundi continues to have large numbers of maternal deaths. Data obtained and compiled by IHPB from the nine hospitals in the IHPB provinces indicate a total of 97 deaths during the period October 2015 to September 30, 2016 with Kirundo and Muyinga hospitals accounting for 29 and 19 deaths respectively and the most causes are severe malaria (45%) and post-partum hemorrhage (21).





One way of reducing maternal mortality is by improving the availability, accessibility, quality and use of services for the treatment of complications that arise during pregnancy and childbirth. Maternal death audit (MDA) is one of the strategies that have proven effective in improving the quality of obstetric care and there are indications that the audits have helped reduce maternal mortality.

In partnership with respective provincial and district health authorities, during the period October 1, 2015 to September 30, 2016, IHPB supported 29 maternal death audit sessions and one near miss audit. The main causes for cases audited were: post-partum hemorrhage, severe malaria and infection

During the FY2016, we noticed there were cases for which it was not easy to conduct audits and for next fiscal year, we decided to collect information on each case of maternal death every week and the audit will be conducted within 30 days.

IHPB will expand training on active management of the third stage of labor to all other health facilities which are not offering uterotonic in the third stage of labor to women giving birth.

Participated in the joint Mission with the Minister of public health in Muyinga and Kirundo:

Given the recent alarmingly high maternal deaths being recorded in Kirundo and Muyinga, IHPB was invited and joined the MPHFA senior staff including the Minister, in joint mission to visit Kirundo and Muyinga hospitals and Kinazi health center in Muyinga. Data obtained and compiled by IHPB from the nine hospitals in the IHPB provinces indicate a total of 97 deaths during the period October 2015 to September 30, 2016 with Kirundo and Muyinga hospitals accounting for 29 and 19 deaths respectively.

In Y4, IHPB will continue supporting the government of Burundi to ensure the surveillance of maternal death in health facilities from its intervention area. Related data will be collected every week and audit conducted within 30 days

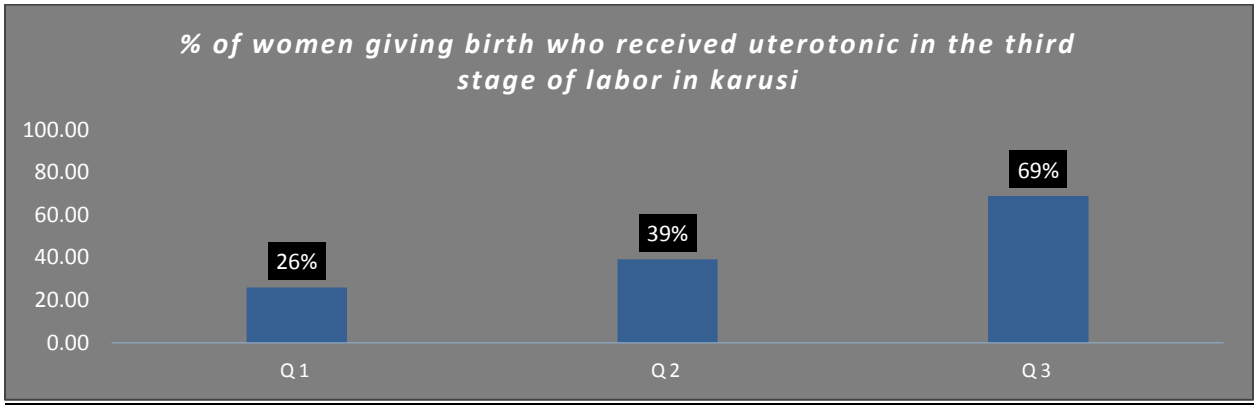
Progress and discussion on the maternal and neonatal health results and indicators

Indicator	Target FY2016	Achieved during FY 2016				
		Oct - Dec	Jan - Mar	Apr - Jun	Jul – Sept	Total
2.0.5 Number/percent of women giving birth who received uterotonic in the third stage of labor through USG-supported programs	7765 (18% of deliveries)	6,066 /10,795 (56.2%)	10,690 /13,695 (78%)	12,066 /14,122 (85%	12,778 /15,509 (82.4%)	41,540/54,211 (77%)
Number of people trained in maternal /newborn through Burundi MCH supported programs	75		60	76		136 (181%)
Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC	50	38	38	38	38	38 (76%)

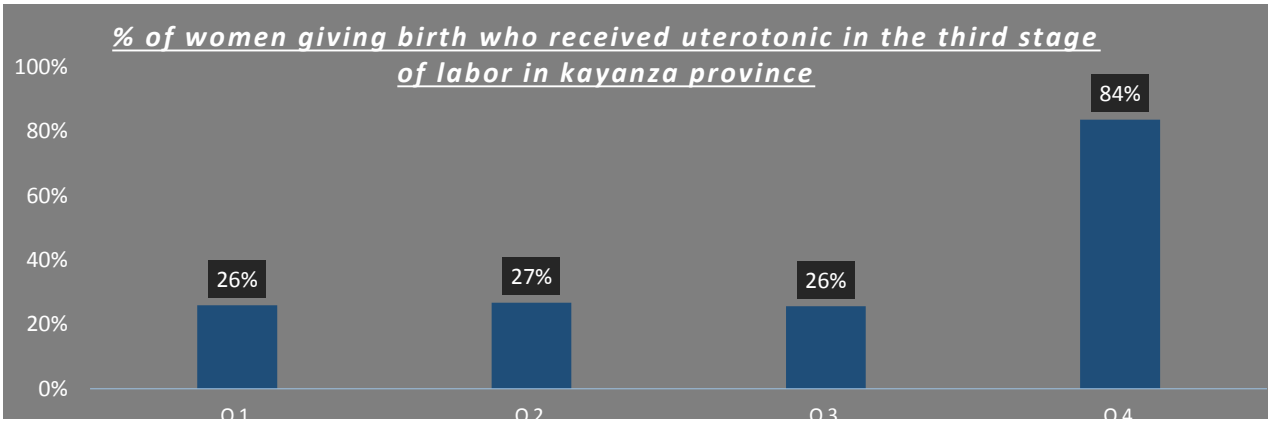
Number of women giving birth who received uterotonic in the third stage of labor through USG-supported programs

The above table shows that in Y3, a total of 41,540 women, representing 77% of the 54,211 who delivered in facilities, received uterotonic during the third phase of labor to prevent postpartum hemorrhage. The target of 18% of deliveries that was set for Y3 was an underestimate.

IHPB worked to strengthen capacity of health providers offering uterotonic to prevent the post-partum hemorrhage and conducted follow up in health facilities to make sure uterotonic drugs are available.
Two examples of good result in two provinces (Karusi and Kayanza) are as follows:



The graph above shows the result from the training conducted during the 2 last years. At the end of FY2016, we have at least 2 health providers trained on active management of the third stage of labor and follow up conducted on field to make sure that uterotonic drugs are available contribute to increase the proportion of women who received uterotonic in the third stage of labor from 26% for the first quarter up to 69% for the third quarter.



The graph above shows the progress of using uterotonic in Kayanza province. At the beginning of FY2016, we had only 10health facilities providing uterotonic in Kayanza and only 26% of women could receive uterotonic. IHPB conducted training to strengthen providers' capacity in offering uterotonic and this contribute to raise the proportion of women receiving uterotonic from 26% at the end the quarter 3 of the FY 2016 to 84% at the end of the FY2016.

Number of people trained in maternal /newborn through Burundi MCH supported programs

The target of 75 set for the Y3 was established according to the trainings we planned and we overreached the target and trained 136 persons (181%). But while conducting supervision and analyzing data related to active management of the third stage of labor (AMTSL), only 26% of women giving birth received uterotonic and we still have health facilities which are not giving uterotonic, we noticed that there we necessity to conduct small easy trainings on AMTSL to prevent post-partum hemorrhage which is the first cause of maternal mortality in Burundi.

Number of USG-supported facilities that provide appropriate life-saving maternity care

(This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC).

The SARA identified 38 health facilities providing life-saving maternity care as defined by the seven signal functions for BEmONC and the nine functions for CEmONC. IHPB conducted training on BEmONC for a total of 86 health providers from 43 health facilities in Karusi, Kirundo, and Muyinga. We need to conduct a survey to better inform how far we are on this indicator.

Reproductive Health Strategy

Planned for Y3	Achievement and results	Comments
Conduct monthly follow-up on FP activities at health facility level	Achieved	35 HF supervised
Train HPTs on community-based distribution of contraceptives	Canceled	HPT were already trained by UNFPA
Organize training of trainers on importance of family planning at the community level	Achieved	22 trainers were trained
Train CHWs and provide tools on the importance of family planning	Achieved	469 CHWs were trained
Organize 12 training sessions on compliance with USG regulations on FP	Partially achieved	8 training sessions conducted 205 people were trained out of 223 planned

Since its inception IHPB has sought to strengthen provider capacity in family planning through training and supportive supervision sessions. In Y3 these include training on modern contraceptive technology, training

on more key concepts and vulnerability factors among adolescents and young people, training on community based distribution of contraceptives. IHPB provided supervision and monthly meetings to ensure the quality of services and data from community activities.
All these activities were implemented in partnership with the National Reproductive Health Program (PNSR) and provincial and district health bureaus and key Y3 achievement included:

Conduct monthly follow-up on reproductive activities health facility level

IHPB, in partnership with health districts supervision in 35 health facilities (16 in Kirundo, 11 in Kayanza province, 5 in Karusi and 3 in Muyinga province), and the major challenges that prevent people from adhering to contraceptive methods are misconceptions by religious leaders and rumors related to family planning in general and to long acting methods in particular. To address these issues, IHPB held a series of meetings with the BPS and BDS to develop strategies and organize regular sensitization and outreach activities. In addition, IHPB conducted formative supervision of health care providers that were trained on youth or adolescent friendly services[7] in Muyinga and found that 3,442 youth attended and received services. These activities were implemented in six health facilities in Muyinga province (Giteranyi (2), Gashoho: (2), and Muyinga (2).

Organize 12 training sessions on compliance with USG regulations on FP

In the work plan we planned to train 223 people, including staff of the project and from the partners. This FY 2016 IHPB was able to train 205 MPHFA staff on USG policies and legislative requirements for organizations receiving USG funds and implementing family planning activities over eight sessions: (169 males and 36 female) health care providers (46 from Karusi, 62 from Kayanza, 64 from Muyinga and 33 staff project).

Training of trainers and training on Community -based distribution of FP methods

Following a five-day training of 22 (15 males and 7 female) trainers from Gahombo district, and four trainers (3 males and 1 female) from the national reproductive health program, IHPB trained a total 469 community health workers (287 males and 182 females) on promoting family planning and the use of 24 contraceptives. The trained CHWs received a tool that will help them during awareness raising meetings in their community. The training covered the following topics: Reproductive Health Concept, Family Planning Concept, Women's Anatomy, Reproductive Physiology, Family Planning Methods, conducting an awareness raising session, materials to be distributed by the Community Health Workers and Data Collection and Reporting.

The project also ordered a kit for CHWs that contains a bag, umbrella, notebook, pen, and boots. The kit will be distributed in May. The results for February and March in Giteranyi district show that 527 individuals (330 new individuals) received methods through community activities; 291 were referred to the health facility.

[7] The World Health Organization (WHO) defines adolescents as those people between 10 and 19 years of age. The great majority of adolescents are, therefore, included in the age-based definition of "child", adopted by the Convention on the Rights of the Child, as a person under the age of 18 years. Other overlapping terms used in this report are youth (defined by the United Nations as 15–24 years) and young people (10–24 years), a term used by WHO and others to combine adolescents and youth.

Organized monthly meeting of community based distributors of contraceptives: IHPB organized monthly meetings of community-based distributors of contraceptives (CBDCs) in Muyinga and Kirundo which are opportunities to collect and analyze data related to community FP activities and these were also opportunities for refreshing CDB agents on FP. Results related to CBD activities are as below:

Raising awareness activities conducted	
Households visited	32,732
# People reached	126,421 reached with FP messages
FP commodities distributed	
Condoms	48,188
Pills	821
People referred to health facilities for modern contraception	1907

Organized Integrated Mobile Clinic on family planning, malaria, nutrition and HIV activities in Gitobe health center area

The activity had been prepared in collaboration with CHWs, local administration, health providers, district supervisors and IHPB staff. This activity took place at the fundamental school of Rugasi in Gitobe commune. One hundred people had been sensitized on the importance of family planning and five people accepted Depo-Provera injectable

Organized three separate communal level meetings

With the objective to discuss and assess access and use of family planning methods, in partnership with Kirundo health authorities, IHPB organized three separate communal level meetings (Bwambarangwe, Gitobe, and Vumbi communes) attended by a total of 95 CHWs (49 males and 46 females), 2 health promotion technicians and 13 health care providers. Discussions focused on timely submission of reports and awareness on family planning.

Organized a session on the following topics: risk behaviors of early and unwanted pregnancy; factors predisposing to unwanted pregnancies and consequences of pregnancy and abortion among young girls

The session was attended by 35 young people (15 boys and 20 girls) and 18 adults (10 men and 8 women). In Kirundo, a low adherence to contraceptive methods was noted and attribute to rumors. It was then recommended to specify the cause of withdrawal of method within the health facility records and redouble efforts to raise awareness of the population with collaboration with the CHWs and the local administrative authorities in order to address these rumors

Organized mobile cinema in 2 communes of Kayanza: in partnership with PNSR, IHPB organized mobile cinema sessions in six sites from two communes of Kayanza (Gatara and Muhanga). The six sites were Gihororo, Gisyo, Muhingira, in Gatara commune and Kibazi, Rugamba, Jimbi, in Muhanga commune. The objective was to sensitize community members on RH/FP and to offer FP methods as well as HIV testing. As results, a total number of 1365 people (540 males and 825 females) were reached with FP messages, 286 people (131 males and 155 females) tested for HIV among who 4 were HIV positive. 437 condoms were distributed and 4 DMPA offered.

Progress and discussion on the family planning results indicators

Indicator	Target FY2016	Number of methods distributed/offered				
		Oct - Dec	Jan – Mar	Apr - Jun	Jul and Aug	**Total**
2.0.1 Couple Years Protection in USG supported programs	136,828					132,567 (97%)
- pills		21,463	25,000	26,952	19,189	
- injectable		46,672	50,884	55,016	38,200	
- condom		36,257	38,348	53,413	42,614	
- IUD		670	771	986	601	
- Implant(Jadelle)		2619	3329	4618	3400	
- Male sterilization		29	2	12	8	
- Female sterilization		19	44	20	17	
2.2.2 Percent of HIV services delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	63%					75%

Couple Years Protection in USG supported programs

This indicator is reported annually. Each method distributed is expected to contribute to increase couple year protection with a specific coefficient. If we consider the number of contraceptive methods distributed up to august, we are at 97% of the target for the couple year protection 132,566.93/136,828) and we can consider the target achieved. Note that we did not have data for September 2016 which are not available. The strategy implemented is to strengthen the community based distribution of contraceptive through which FP messages and information are given by community health workers and we can see that there was an increase of methods distributed from quarter to quarter and this will be closely followed in FY4.

Percent of HIV services delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services

In the intervention in data reported show that at that at the end of the FY 2016 is 75% of HIV services delivery points were providing FP counseling and/or services. This indicator measures the extent of integrated FP/HIV service delivery at SDPs receiving support. Increasing the number of HIV-related SDPs providing FP services will improve access to FP services among clients with unmet need for FP and represent the percent of hospitals and health centers that provides family planning (FP) screening, counseling for FP needs, and FP products or referral to its clients, integrated into HIV services in PEPFAR area (Kayanza and Kirundo). The total number of the sites is 71 out of 95 health facilities in the targeted area. The target was achieved at 109% and we are over the end-of-project target which is 70%.

HIV/AIDS Strategy

Planned for Y3	Achievement and results	Comments
Conduct two one-day sensitization sessions of district hospitals workers per district hospital	Achieved	10 sensitization sessions held in Kayanza, Kirundo, Mukenke, Musema and Gahombo district hospitals. They are performing HTC targeting patients most likely at risk of HIV infection (malnourished children, TB/STI/OI infected, pregnant, labor and delivery women.
Hold a two-day workshop per province to identify potential zones with high risk of HIV infection	Achieved	2 Workshops organized in Kayanza and Kirundo provinces. Participants were informed on fast track strategy and potential hotspots were identified
Targeting potential zones with high risk of HIV infection	Achieved	107 potential zones with high risk of HIV infection identified (Kayanza 90 and Kirundo 17). These places host outreach HTC sessions
Train 30 HTPs on HIV counseling	Achieved	65 Health Technician Promotion (HTP) trained on HIV testing and counseling (Kayanza 50 and Kirundo 15) to conduct outreach HTC in communities
Organize 5 outreach HTC sessions	Achieved	349 outreach HTC sessions organized in hotspots. Results indicate higher yield of HIV positive cases
Test 1948 OVC and other members of their families for HIV through RBP+ grant	Achieved	2,346 OVC tested for HIV. Those who are tested HIV positive are referred in ART sites.
Support 101 PMTCT sites to offer ARV to reduce MTCT of HIV	Achieved	All the 95 publics and faith-based health centers and district hospitals in Kayanza and Kirundo are offering ARV to reduce MTCT of HIV. MPHFA did not build six additional facilities.
Organize routinely mission of transporting samples	Achieved	622 DBS and 3,128 viral load samples transported from health facilities to one of the following three reference laboratories - INSP or ANSS or CRDBi
Treat victims of SGBV	Achieved	115 victims of SGBV received ARV prophylaxis
Support services for OVC through RBP+ grant	Achieved	2,276 OVC have received psychosocial and health support
Establish 14 new ART sites	Achieved	25 ART sites newly established and mentored through 56 mentoring visits.
Organize mentoring visits (56)	Achieved	
Support transport of 1,457 CD4 samples from health centers to district hospitals through IKGs	Achieved	5,707 CD4 cell count samples transported from health facilities to District Hospitals

Conduct two one-day sensitization sessions of district hospitals workers per district hospital

In partnership with the directors of the district hospitals Kayanza, Kirundo, Mukenke, Musema and Gahombo, IHPB supported sensitization sessions for health care providers to integrate HTC into their care units: Inpatient wards (Internal Medicine, pediatric, Gynecology and obstetrical, surgery) and outpatient units (adult and infant outpatient, emergency). A total number of 126 healthcare providers (64 males and 62 females) participated to the session. Multiple HTC points have been set in different outpatient and inpatient units and health care providers systematically propose HIV test to patients with HIV- potentially related symptoms (tuberculosis, STIs, malnutrition, OIs…).

Hold a two-day workshop per province to identify potential zones with high risk of HIV infection

In partnership with the Directors of Health Province and the National Program against HIV/AIDS and STIs, IHPB supported a one-day workshop to sensitize key stakeholders on the "Fast Track Strategy[8]" and identification of strategies for its implementation in Kayanza and Kirundo provinces. The workshop gathered 125 participants (97 males and 28 females) from Provincial AIDS control Committee (Comité Provincial de lutte contre le SIDA-CPLS), Health Provincial Bureau (Bureau Provincial de Santé-BPS), Health District Bureaus (Bureau du District de Santé-BDS), Faith-Based organizations, Civil Society organizations (SWAA Burundi), Health centers Managers and Health Promotion Technicians (TPS).

Targeting potential zones with potential to show high yield of HIV infection and Organize outreach HTC sessions

As part of the discussions of the workshop mentioned above, potential zones with high risk of HIV infection had been identified and 107 hotspots (90 in Kayanza and 17 in Kirundo) were identified based on high-risk behaviors and environment for HIV transmission (drunkenness, mining activities, and presence of Female Sex Workers (FSW)). The workshops concluded on organizing outreach campaigns for HIV testing and counseling in the targeted zones.

Train 30 HTPs on HIV counseling

In partnership with the Kayanza Provincial/District health Bureaus and through IKGs, IHPB supported five-day training sessions on HIV testing and counseling for HTP and health providers from (i) Kayanza: 50 participants (31 males and 19 females); (ii) Kirundo: 15 participants (12 males and 3 females). The purpose of the training was to strengthen the capacities of HTP on HTC in order to conduct HIV sensitization and HIV testing in communities.

Organize 5 outreach HTC sessions

In collaboration with the Health District and Health Provincial Bureaus, IHPB supported outreach HTC sessions in identified hot spots with high risk of HIV infection targeting groups at great risk of HIV exposure including single mothers, separated couples, men and women with sexual multiple partners, waiters/waitresses and transporters. The session included awareness on the routes of HIV transmission, HIV prevention methods, factors favoring the spread of HIV, HIV testing and counseling, health care for PLHIV as well as testimonies of positive living with HIV. HIV test was organized on site for who wants to know his/her serology status and a total of 349 outreach HTC sessions (256 in Kayanza and 93 in Kayanza) were organized. Results are presented in table below:

	# Participants tested and counseled who received their results		# individuals tested HIV positive (HIV+)	
	Kayanza	Kirundo	Kayanza	Kirundo
Male	4,460	2,657	107	85
Female	6,718	3,240	182	149
Total per province	11,178	5,897	289	234
Total two provinces	17,075		523	

Outreach HTC sessions yielded 3% (523/17,075) of HIV positive individuals and all (523) were referred to ART sites.

[8] Fast Track Strategy is a strategy to accelerate the response to HIV/AIDS in order to achieve the objective of 90% of people living with HIV knowing their HIV status; 90% of people who know their HIV positive status on treatment; and 90% of people on treatment with suppressed viral loads by 2020.

Test 1948 OVC and other members of their families for HIV through RBP+ grant

Through RBP+ grant and in partnership with health facilities, a total of 3158 OVC (1272 males and 1886 females) have been tested for HIV. Among them, 153 (4.84%) OVC (58 males and 95 females) were tested HIV positive and received health care and ARV treatment in different health facilities.

Support 101 PMTCT sites to offer ARV to reduce MTCT of HIV

Through supervision visits, nurses have been assisted for introducing ARV prophylaxis for PMTCT in ANC services. All 95 publics and faith-based health facilities of Kayanza and Kirundo supported by USAID are providing PMTCT services. The remaining 6 were facilities expected to be newly built, which did not happen.

Organize routinely mission of transporting lab samples and lab results

In partnership with Health Districts and through IKGs, IHPB supported transportation of DBS and Viral load samples from health facilities to the reference laboratory (INSP, CRDBi and/or ANSS) and lab results to the health facilities: (i) 443 DBS samples: 133 in Kayanza and 310 in Kirundo and (ii) 2,659 viral load samples: 1113 in Kayanza and 1546 in Kirundo. Supporting transportation of samples allow earlier HIV infection diagnosis and earlier initiating ARV in children (DBS samples) as well as better follow up of patients on ART (VL samples).

This activity is regularly interrupted by the repetitive breakdown of PCR and viral load machine at INSP (Institut National de Santé Publique). IHPB has contracted local private laboratories to allow early HIV diagnosis in infant and better follow up of PLWHA on ARV.

Treat victims of SGBV

IHPB supported health centers and districts hospitals to treat victims of rape. In total 115 victims of rape received ARV prophylaxis in addition to PEP, HIV test, Family planning counseling and methods and psychological support.

Support services for 2,448 OVC through RBP+ grant

Through RBP+ grant, IHPB served a total of 2,276 for school support, healthcare, juridical assistance, psychological assistance, hygienic kits and nutritional counseling

Establish 14 new ART sites and Organize 56 mentoring visits

Twenty-five ART sites (10 in Kayanza and 15 in Kirundo) have been created and strengthened during the period of October 2015 to September 2016 through mentoring visits supported by IHPB. IHPB's support consists of enabling nurses to prescribe and manage antiretroviral therapy (task shifting) as well as providing needed tools (protocol, data collection tools) to these new sites.

Support transport of 1,457 CD4 samples from health centers to district hospitals through IKGs

In partnership with Health Districts, IHPB supported transporting CD4 cell count samples from health facilities to District Hospitals and recuperating results. A total of 4,681 CD4 cell count (3,525 in Kirundo and 1,156 in Kayanza) out of 1,457 planned have been examined. Patients with or under 500 CD4 cell count were put on ART in accordance with the national protocol.

Health worker training on themes related to HIV/AIDS

In partnership with District Health Bureaus and through IKGs, IHPB supported (i) a two five-day training sessions on TB/HIV co-infection management in Kayanza and a number of 81 healthcare providers (49 males and 32 females) have been trained. The purpose of the training was to improve the knowledge of the health care providers and supervisors and District Hospitals of Kayanza, Gahombo and Musema on the management of TB/HIV co-infection to offer better quality services using the national training manual "directives national pour la prise en charge de la Tuberculose et les comordidites". (ii) A two five-day training sessions on manipulation of rapid HIV test in Kirundo for 55 Lab technicians (41 males and 14 females). The purpose of the training was to improve quality of testing using the national manual "module de formation sur le dépistage du VIH integrant le dépistage à initiative du prestataires". (iii) Formative supervision missions, using SIMS tools, focusing on supply chain management system (reagents, medicines, ARV and commodities), HIV laboratory activities and HIV related services delivery.

Progress and discussion on HIV/AIDS results indicators

To assess progress in the implementation of HIV/AIDS activities, IHPB tracks indicators –that are in the IHPB's Performance Monitoring and Evaluation Plan and detailed in their respective performance Indicator Reference Sheets.

2.0.8 Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

A total of 891 HIV-positive pregnant women are currently receiving antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery, which exceeds the target of 492 by 181%, in part due to integration of HTC into ANC services.

2.0.9 Number of individuals who received HTC services and received their test results

A total of 321,944 individuals received HTC services, which represents 321% of the target of 138,048. The overachievement was due to outreach HTC activities in addition to less targeted routine HTC services in health facilities.

The target for the fiscal year on individuals who are tested HIV positive was 4,140. By September, 2016 4,583 individuals were tested positive, which exceeds the target. This performance is the result of strategies that target people more likely to be infected by HIV i.e. outreach HTC sessions in hotspots, index-testing and provider-initiated testing and counseling for suspicious patients will be scaled up.

2.0.10 Number of HIV-positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD).

At total of 8,033 HIV-positive adults and children received HIV related care services for a target of 8,435, representing a 95% performance that can be attributed to the decentralization of HIV services.

Number of HIV-positive adults and children newly enrolled in clinical care: The objective of newly adults and children enrolled in clinical care is 4,124 at the end of the year 3 of the project. At the end of Y3, 2,680 new patients were enrolled in care representing 65% of achievement. IHPB intends to work with PLHIV network to integrate all HIV positive persons in HIV care and scaling up ART decentralization and task shifting will continue

2.0.11 Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit
The expected result for the fiscal year of 50% was exceeded at 61.7% (123% of achievement. Healthcare providers are increasingly aware of screening TB among PLHIV in care. Efforts will be remained for more progress.

2.0.12 Number of infants who had a virologic HIV test within 12 months of birth during the reporting period
Y3 target was to have 61% infants tested for using PCR within 12 months of birth – in Y3, 412 exposed infants (45%) were tested out of 924 HIV positive pregnant women. Despite the repetitive breakdowns of PCR machine at INSP, IHPB contracted a private lab for PCR and viral load services and reached 73% of the target (45%/61%)

2.0.13 *Number of adults and children receiving ART [current] (TA-only)*
The target for Y3 is for 7,200 adults and children to receive ARV in IHPB's targeted provinces. 86% (6,211) of this target has been achieved thanks to decentralization of ART and task shifting approaches and due to 25 new ART sites established.

Number of adults and children newly enrolled on ART: The target for the fiscal year is 3,723 HIV infected patients newly enrolled on ART. Only 2,361 are put on ARV that amounts to 63% of achievement. Fail performance is owing to less demand of HIV care by people tested HIV positive, and low scale up of ART decentralization and non-application of test and treat strategy. The implementation of test and treat strategy and scaling up of ART decentralization in targeted provinces will increase the coverage of ARV therapy. In the other hand, collaboration with PLHIV network to integrate all HIV positive persons in HIV care will contribute enrolling more clients on ART.

Annexes IV and V present progress and achievements for Kayanza and Kirundo provinces respectively. In Kirundo, results are beyond expectations thanks to the early adoption of strategies to achieve 90-90-90 objectives - commitment of health authorities, rigorous outreach HTC, ART decentralization and task shifting strategy are key of the success. Adoption fo outreach HTC strategy targeting individuals at high risk of infection – performance increased from 20% in the first three quarters to 87% in quarter 4. However, few patients testing positive are enrolling in care and treatment – 63% (605 out of 961) because of poor uptake necessitating strong referral systems and collabaration with network of people living with HIV/AIDS.

Comapred to Kayanza, results from Kirundo far exceed expected results - indicators that show wide differences between Kirundo and Kayanza are: Number of HIV positive individuals (235% vs 37%), Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load (140% vs 23%) and Number of adults and children newly enrolled on ART (127% vs 26%).

3.3.3 Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Through RBP+ sub contract, expectations are to support 2,448 OVC. Active beneficiaries served from October 2015 to September 2016 are 1924 OVCs (79%) whose assistance is made of school support, Healthcare, juridical assistance, psychological assistance, hygienic kits and nutritional counseling.

Malaria Strategy

Planned for Y3	Achievement and results	Comments
Mobilize communities and district leaders in Musema HD	Achieved	469 persons sensitized
Conduct a one 5-day training of trainers' session (from Musema) on iCCM/CCM of malaria	Achieved	30 health care providers trained
conduct thirteen 4-day training sessions on CCM of malaria for 286 CHWs in Musema health district	Achieved	286 CHWs trained on CCM of malaria[9]
Support internship of CHWs on CCM of malaria and launch the strategy in Musema HD	Achieved	205 CHWs strengthened during internship at their health center
Conduct three 4-day training sessions of 47 HWs on CCM of malaria in Kirundo (17), Gashoho (15) and Gahombo (15) HDs	Achieved	Kirundo: 17 health care providers trained on CCM of malaria and 24 trainers on iCCM (4 from Gahombo, 6 from Kirundo, 6 from Gashoho, 1 from Kayanza and 7 from IHPB).
Conduct 16, 2-day refresher training of CHWs on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs	Achieved	402 refreshed (Gashoho HD: 160 CHWs and Gahombo HD: 242 CHWs).
Support technical follow-up meeting on CCM of malaria with CHW, in-charge nurses and HPTs at HC and HH levels	Achieved	5 separate technical meetings held in each CCM of malaria area at health center level
Supply/furnish CCM of malaria equipment to CHWs in Gahombo, Kirundo, Gashoho and Kayanza HDs	Achieved	Activity planned every three months
Conduct HH visits to CHWs involved in CCM of malaria	Achieved	380 CHWs households visited (28 CHWs in Kirundo, 144 CHWs in Gashoho, 208 CHWs in Gahombo).
Develop, multiply and distribute 3,200 leaflets on IPTp	Achieved	3,309 leaflets
Conduct supportive supervision visits within HC to improve IPTp implementation, ITN distribution, case management and correct parasitological diagnosis	Achieved	125 health centers visited
Organize two 1-day workshops with religious leaders on the burden of malaria, and their contribution to sensitize people to malaria	Achieved	Muyinga: 235 religious leaders, and Kirundo: 393 participants attended
Support religious leaders to deliver monthly messages to congregations on malaria prevention, care and treatment	Achieved	23 Key messages developed by NMCP and reporting tool distributed
Conduct nine 5-day training sessions on new guidelines of malaria case management to 201 HPs (128 nurses, 36 HD supervisors, nine health provincial supervisors and 28 from hospitals)	Achieved	195 health providers trained

In line with the strategic plan of fight against malaria 2013-2017 and the Malaria Operational Plan 2015, IHPB carried out key activities detailed below:

[9] For iCCM stratety, health providers are trained in one session on all packages (malaria, diarrhea, pneumonia case management) but for CHWs, the introduction of the package is progressive and going step by step. In Musema, the entry way of iCCM was community case management of malaria. After monitor the implementation progress (3-4 months), diarrhea will be introduced and at least, introduce pneumonia case management.

Mobilize communities and district leaders on iCCM/CCM of malaria in Musema health district

In the initial work plan of Y3, Kayanza health district has been proposed by the Ministry of Health/NMCP to implement CCM of malaria. Taking in account of high incidence of malaria in Musema (in 2015: total number of malaria cases: 318,534) than in Kayanza HD (in 2015: total number of malaria cases: 149,817), with the leadership of Kayanza Provincial health authorities, IHPB agreed to implement CCM of malaria in Musema instead of Kayanza HD.

With respect of the Guidance of integrated Community Case Management (iCCM), IHPB in partnership with the National Malaria Control Program (PNILP) and the Direction de l'Offre et de la Demande des Soins (DODS) and Kayanza health authorities organized:

A separate one-day sensitization workshop on iCCM for administrative and health authorities, civil society organizations, and representatives of churches and other public services: 87 participants (48 males and 39 females) attended. At communal level, similar sensitization workshops have been held towards community health workers, chiefs of collines and chiefs of zone from three communes of Musema. 382 participants (135 in Matongo commune: 58 females, 77 males), 102 in Butaganzwa commune: 59 males, 43 females) and 145 in Rango commune (95 males, 50 females) including 11 chiefs of zones and 86 chiefs of collines attended. That was an opportunity to inform stakeholders on the goals of the iCCM guidance and to share experiences and advantages of that strategy.

According to the guidance document on integrated Community Case management at community level (iCCM), two to three CHWs per colline are required to implement iCCM. Thus, for Musema HD, where some collines have more than two CHWs, a selection test identified CHWs able to implement iCCM/CCM of malaria. This test, designed by the MOHFA, was focused on the ability of CHWs to deliver their identification by writing, their level of education and their knowledge of the main health problems that affect children under five years of age. In fact, 205 of 286 CHWs were identified to implement CCM of malaria in Musema HD.

Conduct a one 5-day training of trainers' session (from Musema) on iCCM/CCM of malaria

A five-day training session of trainers on iCCM was held, bringing together 30 participants (5 females and 25 males), including 15 health care providers, 5 health promotion technicians, 5 Musema health districts supervisors, and 5 persons from BPS Kayanza staff. Using the training module from MOHFA, the booklet for CHWs on iCCM, and other materials and tools, this session was conducted by four representatives from Ministry Of Health and Fight against AIDS at central level. The training module and PowerPoint presentations have been shared and distributed to participants.

Conduct thirteen 4-day training sessions on CCM of malaria for 286 CHWs in Musema health district

As Community Case Management (CCM) of malaria was the entry way of iCCM, all the 286 CHWs (154 females, 132 males) from Musema HD have benefited from training sessions during 4-day per session. Each session was made by 22 participants. The CHWs were trained on how to implement CCM of malaria and how to record and report malaria cases with fever from their communities. Using training modules and other material availed by the DODS, these training sessions were conducted by health care providers, health promotion technicians, and health district supervisors.

Support internship of community health workers (CHWs) on Community case management (CCM) of malaria and launch the strategy in Musema health district (HD)

As recommended by the Ministry of Health/NMCP, after trainings and before allowing CHWs to treat malaria at community level, a five-day internship on CCM of malaria have been organized for selected CHWs at each health center of their catchment area. During five days, a number of CHWs that varies from 5 to 10 meet at the health center of their catchment to take care to children with fever under the supervision of a health care and a health promotion technician trained on CCM of malaria. The advantages of these internship are to familiarize selected CHWs with the use of rapid test diagnostic (RDT), filling out registers and with community members coming to seek care. Then, iCCM/community case management of malaria in Musema HD has been launched by communal administrative and health district authorities. This event was an opportunity to distribute a complete kit[10] of CCM of malaria to 205 CHWs.

Conduct three 4-day training sessions of 47 health workers on CCM of malaria in Kirundo (17), Gashoho (15) and Gahombo (15) HDs

In Kirundo HD, where CCM of malaria is going on since 2014 with 1 health care provider trained per health center, in collaboration with health district supervisors, IHPB conducted a 4-day training session for an additional health care provider on CCM of malaria during Y3, then: 17 health care providers (12 males, 5 females) trained. Contingent upon the availability of iCCM commodities and with the consent of Gashoho and Gahombo's Health District Directors, the training of health providers on CCM of malaria will be included in iCCM trainings during Y4.

In replacement, a 5-day training of trainers on iCCM package has been provided to 24 participants (7 females, 17 males) that included: 1health district director of Gashoho, 1 of Gahombo, 1 Kayanza health provincial director and 5 health districts supervisors from Gashoho, 3 from Gahombo and 6 from Kirundo including 7 program technical officers from IHPB.

Conduct 16, 2-day refresher training of CHWs on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs

IHPB staff in coordination with health districts supervisors, health promotion technicians and in-charge nurses organized 2-day refresher trainings of CHWs at each health center. Aspects of CCM of malaria, technical issues related to quality of CCM of malaria (such as: filling out stock cards, calculating commodities used all over the month, register of malaria cases, recognizing danger signs of malaria) have been reviewed. CHWs that the number varies from 8 to 30 CHWs have been gathered at their HC. In Gashoho HD: 160 CHWs and in Gahombo HD: 242 CHWs benefited from the refresher training.

Support technical follow-up meeting on community case management (CCM) of malaria with Community Health Workers (CHWs), in-charge nurses and HPTs at HC and HH levels

In close coordination with nurses and health promotion technicians, IHPB supported 5 separate technical meetings (conducted every two months) on Community Case Management (CCM) of malaria that brought together 159 CHWs (96 males, 63 females) from Gashoho HD, 221 CHWs from Kirundo HD (110 males, 111

[10] Kit for CHWs to begin implementation of CCM of malaria: Registers of cases, referral and requisition book, iCCM module, box, cadena, solar lamp, bag, jerrican, spoons, cup of 500 ml, safety box, box of 50 pairs of gloves, trash can, manual timer, algorithm and job aid for malaria care and use of rapid test diagnostic.

females) and one technical meeting in Musema HD (new CCM of malaria district) that brought together 205 CHWs (96 males and 109 females) at the health center level.

At each technical monthly meeting, the agenda of the meetings was initiated with the consent of health district team, and sought to (i)improve the reporting on CCM of malaria, the calculation of average monthly consumption of malaria commodities, (ii)filling and holding tools, (iii)correcting and submitting monthly report.

In response of CHWs' matters, using brainstorming methodology, supervisory team asked to some wise CHWs to share experience on how to address each of issues raised and then give a reminder about on how to fill tools (register of malaria cases, stock cards).
Supervisor's team took an advantage to correct monthly report of CCM of malaria and told to CHWs to order malaria commodities when it remains 5 blisters of each commodity in their stock.
To support a more consistent availability of malaria commodities, IHPB is following closely the status of stocks at district level and, if need be, avail malaria commodities (if available at central level), by providing logistic and technical assistance.

Then, In April, during a household visits to CHWs in Kirundo HD, the fact was that many CHWs didn't have RDT. IHPB in collaboration with Kirundo heath district team, distributed 400 kits of malaria rapid diagnostic tests from Kirundo health district pharmacy (each kit containing 25 tests) to 16 heath centers to enable them supply 2 RDT kits per community health worker (CHW) to 200 CHWs who experienced stock out of for two weeks.
In Y4, IHPB will closely follow the availability of malaria commodities at community level by updating the average monthly consumption for each community health worker and verify if health centers respect commands from community.

Conduct households' visits to CHWs involved in community case management of malaria

This activity was done one time in a month. With the use of the guide of household's visits, the goal was to ensure storage conditions of malaria tools and commodities, keeping of stock cards and to know the points of view of community members about services offered by CHWs. In Gashoho HD: 50 CHWs, in Gahombo HD: 65 CHWs and in Kirundo HD: 18 CHWs received at least 1 home visit of HPT/health care provider per month. The findings were that (i) some boxes (containing malaria commodities and tools) were broken (ii) some CHWs incorrectly filled out stock cards. Supervisors reminded those CHWs that they should update stock cards daily. IHPB staff recommended to the health district supervisors to make a list of missing materials that have been replaced. IHPB offered on-the-job training to remedy the situation. Community members met, appreciated services delivered by CHWs but unfortunately, deplored stocks out of commodities that happened sometimes and would like also to services on pneumonia and diarrhea at community level.

Supply/furnish CCM of malaria equipment to CHWs in Gahombo, Kirundo, Gashoho and Kayanza HDs

To further support CCM of malaria implementation in Kirundo, Gashoho and Gahombo HD, IHPB distributed boxes of gloves and safety boxes to CHWs through districts' pharmacies. In Musema health district where CCM of malaria should be rolled on, a complete kit, (except RDT's and medication that are supplied by the health center) has been provided to 208 CHWs. In response to the need of soaps expressed by CHWs during monthly meetings, IHPB bought and distributed 1 box of 24 pieces of soap to each CHW.

In line with MPHFA's priorities and with the commitment of IHPB to strengthen the community case management, Malaria and Supply Chain specialist coordinated to send iCCM commodities from UNICEF to the four IHPB' area with community case management of malaria: Gahombo, Gashoho, Kirundo and Musema where iCCM will be expanded. Commodities included 510 boxes (51,000 tablets) of Amoxicillin 250mg, 3,920 boxes (392,000 tablets) of Zinc 20 mg and 20,000 sachets of oral rehydration salt. These commodities will be used to implement pneumonia and diarrhea case management in the four districts.

Develop, multiply and distribute leaflets on IPTp

In close coordination with the staff of the National Malaria Control Program (NMCP) and the staff of Information, Education and Communication service (IEC), messages on the importance of SP in IPTp were developed and pre-tested. Thus 3,309 leaflets bearing information (in Kirundi) were produced and distributed to CHWs (3,250: one copy each) and to HPTs (59). To ensure the comprehension and good use of the leaflets, IHPB in coordination with health promotion technicians organized, at communal level, a one-day training-sensitization session across the 12 IHPB districts. A total of 3,250 CHWs (1,285 F and 1,965 M) attended.

Conduct supportive supervision visits within health centers to improve IPTp implementation, ITN distribution, case management of malaria

Using the supervision tool[11] developed by NMCP, with the objective to improve malaria interventions, supportive supervision visits focused on improving IPTp reporting and SP administration during ante natal care (ANC), integration of LLINs and respect of malaria treatment guidelines,IHPB, in partnership with health district supervisors, conducted at least one join supportive supervision visits in 125 facilities for 12 health districts in partnership with HD staff: Muyinga (15), Gashoho (12) Giteranyi (15), Buhiga (16) Nyabikere (18), Kirundo (2), Busoni (3), Mukenke (6) and Vumbi(11), Kayanza (9), Musema (8) and Gahombo (10).

In all health facilities visited, some of strengths were: availability of guidelines of malaria treatment, the consultation registers well filled. But around 40% of facilities experienced stock-out of SP (because of underestimation of needs) and in health centers did not master how to complete the IPTp reporting tool, mismatch between recorded data and data in the register, the first dose of SP is not taken under observation of health provider, clients don't receive explanation on how to take medication prescribed and poor reporting on the consumption of anti-malaria drugs.

Supervisor's team took time to discuss with each health facility team visited by encouraging their strengths and shared experience to improve reporting and the quality of services delivered. The supervisor's team showed the downside of each weakness and health providers with supervisors proposed technical solutions to improve, such as: to avail water and jerrican in the ante natal care room, to analyze and summarize data progressively each week in a team of two persons and keep in mind to complete stock cards every day or before beginning health facility's activities.

[11] The integrated supervision tool contains information on: availability of modules and malaria commodities, verifying if all malaria cases treated have been tested, how malaria commodity tools are keeping, comparing number of cases treated and anti-malaria drugs used, comparing number of pregnant women attending ANC1 and number of LLIN distributed and comparing number of pregnant women attending ANC and number that received SP.

In response to the malaria outbreak that affected 11 provinces and the 12 IHPB health districts over a two-week period, IHPB provided technical and financial support to carry out mobile clinics and outreach treatment activities during outbreaks of malaria period. Then IHPB availed its project staff and vehicles (including allowances) to carry out mobile clinics and outreach treatment activities. Out of 173,531 people that were tested: 169,276 including 105,335 children under five years were positive and treated for malaria.

Also, jointly with USAID's Malaria Specialist, IHPB conducted visits to six (6) facilities in four health districts: Kirundo: 2 (Kirundo hospital and Kirundo HC), Vumbi: 1(Vumbi HC), Kayanza: 1(Rugazi) and Giteranyi: 2(Giteranyi, Ngomo HC). Discussions during the visits focused on evolution of malaria cases from February to June 2016 and availability of commodities at facility and community level. Comparing cases in April and May 2014, 2015 and 2016, the fact is that there was a high level of malaria incidence during that period every year. Comparing malaria data during the outbreak period in February 2016, monthly reports showed that the number of malaria cases have decreased from February 2016 (e.g. for Ngomo HC: in February 2016: 1,077 cases, in March2016: 1,270 and in April 2016: 475 cases of malaria).

Organize two 1-day workshops with religious leaders on the burden of malaria, and their contribution to sensitize people to malaria

Malaria is a big health problem that affects everybody with a high level of vulnerability for pregnant women and children under five. Then, to ensure a high level of knowledge and adopting good practices of fighting against malaria, IHPB organized a one-day sensitization workshop to religious leaders. The goal was to show, with malaria data at provincial and health district level, how malaria is a burden for health and for economy of households and thus to involve them to take part in activities related to fight. In Muyinga and Kirundo Province, workshops were held separately per health district and brought together 270 participants from Muyinga and 393 from Kirundo province. Giteranyi HD: 119 religious leaders (114 males, 05 females), Muyinga HD: 116 (03 females, 113 males), Gashoho HD: 35 (04 females, 31 males), Kirundo HD**:** 157 (23 females and 134 males); Busoni: 70 (4 females and 66 males); Vumbi: 77 (19 females and 58 males) and Mukenke HD: 89 (5 females and 84 males) participants attended.

The Governor of Muyinga province was the chairman of the workshop in Muyinga Province. After power point presentations done by health provincial director, health districts directors and NMCP staff, participants have been dispatched in groups to commit on how they will act in fighting against malaria. Then they commit to deliver messages in each sermon and at community level when they make field visit within their congregations (messages related to seeking care early in case of fever, to using ITN as well as recommended, to seeking ante natal care very early for pregnant women). Religious leaders committed to give their best in fight against malaria.

Support religious leaders to deliver monthly messages to congregations on malaria prevention, care and treatment

A guide on the 23 key messages[12] has been distributed to religious leaders and a reporting tool[13] that should be submitted to their health center.

Conduct training sessions on new guidelines of malaria case management.

In partnership with Kayanza, Gahombo, Musema, Kirundo, Mukenke, Busoni, Vumbi, Buhiga and Nyabikere HD trainers, IHPB organized 9, 5-day training sessions on new guidelines of malaria case management by health workers. The new guideline includes treatment of severe malaria using intravenous Arthesunate in pre-referral and Quinine + Clindamycin in case of severe malaria. The table below summarizes the profiles and number of attendees per district.

District	Nurses trained (HC)	Health care providers from districts hospital	HD supervisors	Sex		Total
				M	F	
Buhiga	16	10	2	16	12	28
Nyabikere	18	0	3	12	9	21
Vumbi	14	0	1	13	2	15
Mukenke	10	6	2	15	3	18
Kirundo	17	6	2	14	11	25
Busoni	9	0	2	9	2	11
Kayanza	15	8	4	14	13	27
Gahombo	14	9	1	18	6	24
Musema	15	9	2	12	14	26
Total	128	48	19	123	72	**195**

195 participants attended when 6 participants (2 from Kirundo, 2 from Nyabikere, 1 from Buhiga and 1 from Vumbi) were busy with other activities. Unfortunately, there is stock out of clindamycin tablet from April 2016 at national level. Thus, treatment of severe malaria is based only on Quinine and artesunate intravenous.

[12] The set of 23 key messages of malaria distributed includes messages on prevention (benefits of use of ITN and IPTp for pregnant women, where find and how use ITN, environmental hygiene) on case management (seek care early in case of fever, take malaria medicines as recommended) and on public awareness (everyone is concerned with malaria, involving makers-decision at community level).

[13] The reporting tool include information about: # of persons sensitized on malaria prevention/visited, sex, talking point and the place.

Organize a three-day interactive theater[14] in Gatara and Muhanga communes/Gahombo HD

In partnership with Gahombo health district (Kayanza province), IHPB organized a three-day interactive theater event using a local music, dance and drama group that focused on malaria prevention, early care seeking, and the use of insecticide-treated nets and IPTp. The event was held in three sites of the two most affected communes (Muhanga and Gatara) and attended by 855 people (452 males and 403 females).

Participated in 4 coordination meetings including 3 organized by: Direction de l'Offre et de la Demande des Soins (DODS) and 1 organized by the National Malaria Control Program (NMCP). With DODS, -in different meetings- discussions focused (i)on mapping of iCCM partners, update of package that partners support and harmonizing of reporting template of iCCM activities-on(ii) expanding integrated community case management (iCCM) in heath districts where community case management (CCM) of malaria is being implemented.

As IHPB is engaged in health child, UNICEF committed to providing 51,000 tablets of Amoxicillin (250mg) 392,000 tablets of Zinc (20 mg) and 20,000 sachets of oral rehydration salt for implementing iCCM in the four (Gahombo, Gashoho, Kirundo, Musema) IHPB CCM of malaria HDs.

In the coordination meeting conducted by national Malaria Control Program, discussions focused on – assessment of quarter 1 achievements- sharing information on the situation of malaria cases from the period of outbreaks until April- stocks out of ACT (2-11 months, 1-5 years) due to the excessive consumption during outbreaks and forecasts of malaria commodities ordered for an eventual peak in May and in October 2016.

Progress and discussion on the malaria results indicators

Indicator	Target FY2016	Achieved to date (oct.2015-August 2016)
% of children under one year who had received LLINs through USG funds	95%	89%
% of pregnant women who had received LLINs during ANCs through USG funds	94%	81%
% of children under five with fever who received ACT within 24 hours of onset of fever.	75%	74%
% of pregnant women who received IPTp during ANC visit	60	68%
Number of health care providers trained on CCM of malaria/iCCM	77	71
Number of community health workers trained on CCM of malaria	286	208
Number of CHWs refreshed on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs	402	402
Number of health providers trained on new guidelines of malaria case management	201	195

[14] Interactive theater is a community theater: HD staff and IHPB agree on a topic to share with community members and share it with a local group theater. This last develops the topic and presents it as a theater in presence of a large number of persons at a communal level where many persons meet, preferably in the afternoon. After playing, spectators give the feedback of what they learnt and their commitment. Communal administrators and health district representatives insist on the key messages delivered and the roles of community members.

% of children under one year who had received LLINs through USG funds

IHPB accessed aggregated data from the National Health Information Management System (DHIS2) database. Given that the level of achievement of this indicator up to date is 89% and the target estimated at 95%, we strongly believe that the Y3:2016 target is not achieved and the target was ambitious. However, we mention that this indicator varies from a month to another: in October 2015 and in June 2016, nearly 77% of children received ITN during measles immunization when from December 2015 till April 2016, more than 95 % of children that coming for measles immunization received ITN. IHPB is only responsible for awareness not for supply of LLINs.

% of pregnant women who had received LLINs during ANCs through USG funds

The IHPB accessed aggregated data from the National Health Information Management System (DHIS2) database. We believe that the level of achievement of the indicator is low: 80% when the target at the end of the year is estimated at 94%. During supervision visits in health facilities, some health centers experienced stocks out of ITN all over a month and pregnant women that missed ITN during ANC didn't receive another appointment for receiving ITN. IHPB is only responsible for awareness not for supply of LLINs.

% of children under five with fever who received ACT within 24 hours of onset of fever

CCM of Malaria (PECADOM) is implemented in 4 health districts that including Kirundo, Gahombo, Gashoho and recently Musema (from May 2016). During Y3: 134,740 children under five have been tested for malaria with a rapid test diagnostic (RDT) and among them: 100,550 were positive for malaria and received ACT. The outbreaks of malaria in February 2016 has been followed by a stock out of ACT for 1-5 years at central level but these commodities were available at peripheral level. Considering the level of achievement in Y3: 74,6% (100,550/134,740) of children that received ACT within 24 hours of onset of fever, we believe that the target: 75% is nearly achieved.

% of pregnant women who received IPTp during ANC visit

As shown in the table above, the level of achievement of this indicator is exceeded. Achieved up to date is 67.6%, when estimated target is 60%.

Number of health care providers trained on CCM of malaria/iCCM

In Kirundo HD, where CCM of malaria is going on since 2014 with on health care provider trained per health center, an additional health care provider has been trained on CCM of malaria during Y3, then: 17 health care providers form Kirundo HD. In Musema health district (new iCCM health district): 30 health providers including 15 nurses, 5 health district supervisors, 5 health promotion technicians and 5 health provincial supervisors trained on iCCM (malaria, pneumonia, diarrhea and screening for malnutrition).

IHPB expected to train an additional health care provider each health center of Gashoho and Gahombo during FY3. Contingent upon the availability of iCCM commodities, that training has been replaced by a 5-day training of trainers of 24 participants on iCCM package: 4 from Gahombo, 6 from Kirundo and 6 from Gashoho. Health care providers from those districts will be trained in Y4.

Number of community health workers trained on CCM of malaria in Musema HD: Musema HD counts 286 CHWs, but 208 CHWs[15] have been identified by a selection test to implement community integrated community case management /iCCM (Malaria, diarrhea and pneumonia) that the entry way was Community case management of malaria in Musema HD. Even though, all the 286 CHWs benefited from the training on community case management of malaria. In case that a CHW gives up, it will be easy to replace him with another one already trained.

[15] With the respect of what said in the guidance document on iCCM: two to three CHWs per colline are required in implementation of iCCM.

Number of CHWs refreshed on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs

242 CHWs in Gahombo HD and 160 CHWs in Gashoho HD that are implementing CCM of malaria since 2012, have benefited from a refresher training on CCM of malaria and informed on the additional package of community care for children under five years (diarrhea and pneumonia).

Number of health providers trained on new guidelines of malaria case management

During Y2, one health provider from Muyinga, Giteranyi and Gashoho HD had been trained on the new guidelines of malaria case management. During Y3, 201 health care providers from nine health districts (Gahombo, Kayanza, Musema, Kirundo, Vumbi, Mukenke, Busoni, Nyabikere and Buhiga) have been targeted to be trained on new guidelines of malaria case management. Thus 195 health providers have been trained. On all over the training sessions, 6 supervisors were absent. IHPB collected lists of participants which describe their profile and their origin.

Child Health Strategy

Planned for Y3	Achievement and results	Comments
Improve immunization services		
Work with BDS health information system managers to identify health facilities with immunization coverage <70%	Achieved	16 health centers were identified with low coverage
Conduct joint visits (BDS/IHPB) in health facilities with immunization coverage <70%	Partially Achieved	Joint visits were conducted in 8 health centers (out of the 16)
Conduct root-cause analysis of low immunization coverage	Partially Achieved	Root-causes analysis was conducted in 8 health centers (out of 16)
Suggest activities to address identified causes of low immunization coverage	Achieved	Activities were suggested, some of them have been carried out, others will be achieved in year 4
Improve clinical IMCI		
Support BDS to conduct three 5-day training sessions for 90 health care providers from Karusi and Kirundo on clinical IMCI	Achieved	88 health care providers were trained
Support the BDS to conduct a post-IMCI training follow up in 80 health centers on the basis of 20 HCs per quarter	Partially Achieved	11 HCs were supervised
Improve nutrition services		
Conduct a 5-day training for 92 health care providers from Kirundo, Vumbi and Nyabikere health districts on the National Protocol of Malnutrition Management	Partially Achieved	61 health care providers were trained
Conduct a post-training follow up with BDS for 27 health facilities	Partially Achieved	5 HCs were supervised

In child health area, IHPB conducts activities to improve three main components: immunization, nutrition, and the Integrated Management of Childhood Illnesses (IMCI). During year 3, IHPB implemented the following activities:

Work with BDS health information system managers to identify health facilities with immunization coverage <70% and conduct root-cause analysis

In collaboration with the health information managers in health district offices, IHPB program technical officers identified health centers with immunization coverage less than 70% to undertake activities to raise it. The health centers identified are: Nzewe, Gasenyi II, Ceyerezi, Kibaribari, and Ngoro in Gahombo health district; Kabuye I, Murima, Gahahe, Nyabihogo, and Mubuga in Kayanza health district; Burarana, Kabuye2, Nyarurama, Karehe, Nyarumanga, and Musema in Musema health district.

Joint supervision was conducted by IHPB and health district offices in 8 of the health centers (5 in Gahombo health district and 3 in Musema health district) identified as having low maternal and child health indicators including immunization coverage. The aim of the visit was to conduct root causes analysis of the low performance. The main weaknesses noted in child health are: the fridge not well maintained or broken down; high level of dropout of immunization and the lack of recovery strategy; administration officials are not involved in resolving health issues; a lack of synergy between CHWs and local administration officials; a bad recording of children vaccinated. Some activities were consequently suggested to resolve the problems identified such as: organize workshops to mobilize community and sensitize community leaders; organize community drama; conduct joint supervision of immunization services. In year4, focus will be put on the use of immunization surveillance registers by CHWs to identify children who have never been vaccinated, and those who are late to getting additional vaccines; support health districts to conduct quarterly cold chain maintenance in health centers with technical assistance from EPI; and conducting joint visits by IHPB program technical officers and health district offices to health facilities to carry out integrated supervision including for immunization.

Suggested and carried out activities to address identified causes of low immunization coverage:

1) Hold workshops for community mobilization and community leaders' sensitization

Workshops were held by IHPB in collaboration with the health district offices to mobilize community on the maternal and child health comprising immunization. Indeed, the root causes analysis found, among other causes of low performance: CHWs work not corroborated by administration officials; and the lack of synergy in community sensitization. Thus, workshops were organized, involving health officials at district level, administrative officials at commune level, and community members including community health workers. Recommendations were addressed to administration officials at colline level to collaborate with CHWs in sensitizing and mobilizing community on health-related matters, and to mobilize community to attend the community drama; health facilities were recommended to improve registering and follow up immunization dropout cases. These workshops contributed to over achieving the annual target for the indicator "Number/percent of children who received DPT3 by 12 months of age" from 96,140 to 98,166.

2) Conduct joint supervision on immunization

A joint supervision IHPB/District was conducted in five health centers identified as less performing in MCH-related indicators in Gahombo health district: Nzewe, Gasenyi II, Ceyerezi, Kibaribari, and Ngoro. The supervision was conducted by 2 district supervisors and the IHPB technical program officer; the head of health center and the health provider in charge of immunization service were supervised. The cold chain was analyzed because in 3 health centers (Gahombo, Mubogora, and GasenyiI) fridges were no longer used because users claimed they had dysfunction. Observations revealed that temperature inside the fridges was very varying causing a risk of vaccines denaturation. A spare called *« CAROTTE »* was systematically replaced and a 3-day observation period was recommended. It was also recommended to assign a staff to follow up of fridge functionality.

Support BDS to conduct three 5-day training sessions for health care providers from Karusi and Kirundo on clinical IMCI

In collaboration with the MPHFA, IHPB conducted, in 3 sessions, a 5-day training for 88 health center-based care providers (23 females and 55 males) from Karusi and Kirundo provinces. The training consists in capacity building in using the algorithm of the 6 main symptoms responsible of morbidity and mortality in children under 5 years of age: Cough, diarrhea, Fever, ear problem, Anemia, and Malnutrition for children aged from 2months to 5 years; and bacterial Infection, Icterus, birth weight, Diarrhea, HIV status, feeding for children aged from o to 2 months. The training was facilitated by a national team of 12 trainers coming from different level of the MPHFA (6 from the central level, 4 medical doctors from hospitals, and 1 person from a district health office) and 1 staff of IHPB.

The training was conducted in two phases: theoretical phase (3 days) and practical phase (2 days) with evaluation. The evaluation of each trainee considers the number of cases seen and the score. All the trainees saw more than 20 cases and had at least 88%. The WHO recommends a minimum of 20 cases by trainee, and minimum score of 85%; all the trainees were therefore declared capable to implement the IMCI approach.

Support the BDS to conduct a post-IMCI training follow up in health centers

A follow up visit was conducted to 11 health centers in Karusi province from which health care providers have been trained on clinical IMCI. The follow up visit was conducted by a team including one supervisor from the health district office and one person from Karusi IHPB office. The objectives of the activity were: 1) assess the level of implementation of the acquired knowledge; 2) assess the difficulties that trained providers are having to apply knowledge received in training; 3) strengthen the capacity of providers trained to optimize the implementation of the approach; 4) incite the BDS to include this aspect in their routine supervision. Positive points were noted such as: availability of tools (IMCI guide, Weight/Height table, MUAC, registers, IMCI forms); a restitution of the training was made by the trainees to the rest of the staff in some health centers; CHWs refer malnutrition cases from community to health centers; Systematic malnutrition screening for children aged of less than 5 years in HCs; health care providers assume application of IMCI approach allow them to improve quality of care for children. However, weaknesses were also identified such as: no restitution on training was made in some HCs (Rabiro and Gihogazi); difficulty to interpret the W/H table; classification of nutritional status is not marked in the register; stockout of some drugs; and general danger signs are not mastered by all providers. Supervisors demonstrated the aspects for which health care providers revealed to be weak such as**:** how to interpret the W/H table, how to search danger signs, how to fill the register, etc.

Supervisees committed to improve clinical IMCI approach application; the supervisor from the district health office committed to continue coaching health centers on applying the approach, while IHPB was requested to support training of more health care providers on the approach.

Conduct 5--day trainings for health care providers from Kirundo, Vumbi and Nyabikere health districts on the National Protocol of Malnutrition Management

In collaboration with district and province health services, IHPB conducted a 5-day training for 61 participants (28 females and 33 males) from Nyabikere and Buhiga health districts, including 51 health center-based nurses, 4 hospital-based nurses, 2 hospital-based medical doctors, 3 supervisors of district and one medical chief of district.

The trainers' team included trainers from the health district and the province health offices, and from IHPB staff. The training included the following subject: nutrition concepts and factors influencing nutritional status; cycle of malnutrition-infection; causes and consequences of malnutrition; community component of acute malnutrition management protocol; screening of malnutrition ; transport of severe malnutrition cases; outpatient: Structure, Admission, Follow up and discharge; Stabilization service for

children aged of 6 to 59 months : Admission, care and complications; Stabilization service for children aged of 0 to 6 months ; nutritional supplementation Service ; and nutritional education.

In addition to planned activities, IHPB implemented the following activities:

Integrated supervision of MCH services in Karusi province

An integrated supervision of MCH services was conducted, in February 2016, in 5 health centers of Karusi province; the integrated management of childhood illnesses, immunization, and acute malnutrition management were supervised. The weaknesses noted are: Some health centers with no personnel trained on IMCI; Ineffective allocation of personnel in different services according to their capacity. i.e. nurses trained on IMCI are not affected in children consultation; Ineffective coordination between CHWs activities and activities in health centers; No follow-up system for cases of immunization dropout. Recommendations were addressed to the health centers heads to correct the weaknesses noted such as appointing the staff according to the trainings each one has had. However, activities were consequently decided: Organize quarterly mentoring meetings gathering CHWs, health promotion technicians, and health center heads; initiate a strategy of immunization surveillance by CHWs where each CHW will be provided with a register to record all the children less than 2 years old and follow up the immunization schedule completion; training CHWs on community component of IMCI.

Child death audit in Gahombo health district

A child death audit was conducted in Gahombo hospital to analyze and criticize, search gaps in the quality of care and suggest solutions of quality improvement. The audit gathered 18 participants including 9 health care providers from hospital, 9 from health centers, and 3 from the health district office.

A case was presented and discussion engaged on it: a child aged of 2 years brought directly to emergency service (not referred from health center) in coma, fever, and convulsions. The malaria test was negative; he was treated like severe malaria and died after 2 days. It was noted: a belated health service request, weaknesses in CHWs activities, hierarchy of care not followed.

Progress and discussion on the child health results indicators

Indicator	**Target FY 2016**	**Achieved to date FY 2016**				
		Oct-Dec 2015	Jan-March 2016	April-June 2016	July - Aug 2016	Total
2.0.4 Number/percent of children who received DPT3 by 12 months of age	82%	16,865/18,231 (92.5%)	16,719/18,231 (92%)	18,655/18,231 (102%)	18,624 /18,231 (102%)	70,863 /72,924 (97.2%)
2.0.6 Number/percent of women reached with education on exclusive breastfeeding	115,000	41,743	42,363	48,701	78,479	211,286 (184%)

Number/percent of children who received DPT3 by 12 months of age: Data are daily collected in Immunization registers and forms, and reported monthly to the district on facility monthly reporting forms. The target for 2016 fiscal year is 82%; the achievement up to August 2016 is 97.2% (70,863/72,924. Different strategies implemented helped to overachieve the target: hold workshop to mobilize community leaders on immunization in Kayanza province, introduce immunization surveillance by CHWs in Karusi province and the revival of the strategy in Kayanza and Kirundo where it had been introduced in the past and given up after, the joint supervisions of immunization services, etc.

Number/percent of women reached with education on exclusive breastfeeding: The indicator represents the number of women reached with education on exclusive breastfeeding conducted by community health workers through home visits and community meetings. The information is collected in CHWs monthly reports. The target for 2016 fiscal year is 115,000; the achievement up to August 2016 is 211,286, representing 184% of the target. The target is already overachieved; this is due to the fact that activities were scaled up during Y3. In fact, the community component of IMCI and the community based management of malnutrition that were initially implemented in Kayanza and Muyinga provinces were extended to Nyabikere health district in Karusi province and Vumbi health district in Kirundo province.

Innovation Study

Planned for Y3	Achievement and Results	Comments
Constitute a Technical Advisory Group (TAG)	Achieved	A TAG was appointed by the MPHFA
Meetings with implementing partners (BPS, BDS, etc.)	Delayed	Meetings will start early November
Protocol submission to Burundi National Ethics Committee	Achieved	Protocol approved by Burundi National Ethics Committee
Protocol development and approval by FHI 360, Burundi Ethics Committee and ISTEEBU	Achieved	All approvals required were obtained
Tools (health provider manual, job aids) development	Achieved	Health provider manual and job aids developed
Implementation and follow up (training, data collection, supervisions)	Ongoing	Testing of Data Collection Form achieved

The pilot study for the integration of PMTCT and EID of HIV into routine newborn and child healthcare was selected to be implemented during Y3. During this year, IHPB submitted the protocol and its appendices to FHI 360's Protection of Human Subjects Committee (PHSC), the National Ethics Committee and ISTEEBU and obtained required authorizations from these institutions. During Year 3, the following activities were achieved:

Submit the protocol to the FHI360 Protection of Human Subjects Committee (PHSC)
The principal investigators of the study submitted the protocol and its appendices to the FHI360 headquarters staff who provide technical assistance to IHPB project. The headquarters staff reviewed these documents, provided their comments and returned them to the principal investigators for amendments before submission to the PHSC. PHSC members who reviewed the protocol and its appendices, after initial amendments, asked for clarifications, provided comments and made suggestions for improvements. After addressing the questions and comments and making relevant revisions, IHPB resubmitted the documents to the PHSC. The FHI 360 PHSC provided approval for implementation.

Submit the protocol to the Burundi Ethics Committee
The Protocol and its appendices (translated into French) were submitted to the Burundi National Ethics Committee. They were reviewed by the committee, especially on the ethics aspects, for clarifications and provided the approval for the go-ahead.

Submit the protocol to the ISTEEBU

After approval by the Burundi Ethics Committee, the Protocol and its appendices were transmitted to the Ministry of Good governance and Planning and the Institute of Statistics and Economic Studies of Burundi (ISTEEBU) which issued the statistics visa authorizing the implementation of the study.

Conduct testing of Data Collection Forms

The Data Collection Forms were pre-tested over a period of two weeks in Kirundo province (Vumbi district) which is similar to Kayanza Province. Pre-testing served to test not only the forms themselves but also to assure the availability and location of all needed registers, and to measure the length of time needed to record data. After pre-testing, the data collection forms were modified according the findings. The length of time foreseen to record data was not modified as it was deemed to be sufficient.

Learning, Documentation and Dissemination

Planned for Y3	Achievement and results	Comments
Confirm Q1 knowledge products to be generated, target audience, and dissemination strategy for each	Achieved	▪ Confirmed three knowledge products to be produced in Q1 (Fact sheets, Newsletters and Success Stories)
Generate ≥3 knowledge products for Q1	Achieved	▪ Drafted technical briefing fact sheets summarizing key findings from the Gender Assessment, SBCC Assessment, SARA and FQA ▪ Published a newsletter on the community case management of malaria ▪ Two success stories on Community Case Management of Malaria and Intermittent Preventive Treatment (IPTp) of Malaria during Pregnancy.
Select topics and formats for, generate, and disseminate Q2 knowledge products	Achieved	▪ *I* ▪ Produced two newsletters featuring CSOs and HIV/AIDS progress ▪ Produced three success stories on HIV/AIDS
Select topics and formats for, generate, and disseminate Q3 knowledge products	Achieved	▪ Published and disseminated booklet on *Child Health: The Seven practices of Community Component of IMCI* ▪ Published two newsletters ▪ Produced two success stories on incubators in Kirundo and IPTp in Karusi
Select topics and formats for, generate, and disseminate Q4 knowledge products	Achieved	▪ Documented QI activities and drafted related newsletter ▪ USAID IHPB produced three success stories on IPTp, MNCH and Community Case Management of Malnutrition.
Draft, refine, and submit abstract(s) to AIDS 2016 Prepare and deliver poster or oral presentation for AIDS 2016	Not achieved	The abstracts were drafted however the project team did not have sufficient time to finalize and submit them for the conference. As a result, no poster or presentation was prepared.

IHPB is committed to sharing knowledge generated across project activities for the benefit of local partners and institutions and international health and development disciplines more broadly. While the precarious security situation hampered some dissemination activities in Y3, the project succeeded in producing 16 communication and knowledge products including newsletters on malaria with iCCM and IPTp, progress towards HIV/AIDS targets, CSO partnership experiences, and advances in MNH with EONC and AMSTL; success stories highlighting project beneficiary experiences; and an IMCI booklet for CHWs; among others. The project also finalized and began utilizing analyses of the significant volume of data generated through the FABs which reveal important insights into health-seeking behaviors and barriers related to sexual, reproductive, maternal and child health, malaria and HIV/AIDS at individual, household and community levels; the availability and quality of services at community and facility levels; the state of the district health system; and gender roles, norms, and disparities affecting health in Burundi.

Key Y3 achievements include the following:

On a quarterly basis, identified and prioritized potential learning opportunities that cut across Sub-CLINs, program and technical areas

The project began systematically identifying and prioritizing learning opportunities. These include 'mining' the FABs and District Reports for additional insights; successes in iCCM implementation, GATPA and AMSTL; and substantial progress in QI, CSOs transition, and ART decentralization process. IHPB began summarizing findings from FABs into Fact Sheets and convened a Learning Workshop in Karusi to share district-level results from the SARA and HHS FABs. In Y4 IHPB will pursue additional learning activities at district and national levels per the Y4 work plan.

Continued the "IHPB News" publication, a newsletter that presents and summarizes key project activities IHPB produced four issues of the newsletter in Y4, starting with Issue #7 in December 2015 focused on the community case management of malaria (PECADOM), showing how this new community approach with trained and equipped CHWs makes a difference in improving the early care of children and helps to reduce severe cases of malaria at health center level. Issue #8 presented IHPB progress in strengthening the capacity of three CSOs, their high scores and graduation to be able to receive USAID funds. Issue #9 focused on HIV/AIDS and showed the progress in decentralizing ART services as well as care and support for OVC. Issue #10 focused on maternal, newborn and child health services and presented the impact of IHPB-donated incubators in saving lives as well and the impact of training on essential neonatal and obstetric care.

Published 10 success stories

IHPB published ten success stories including one on the CCM of malaria. In one, CHW Therese Nzirorera commented that *"Since I became a CHW, I never dreamed to become one day a practitioner. After the training I received last year, I started doing malaria testing and giving medication. People have increased their confidence in me and come to me whenever a child has fever.*" Other stories presented successful implementation of IPTp in Nyabikere health district; the impact of HIV/AIDS treatment and care for OVC in Kirundo by IHPB partner ANSS; successful decentralization of ART in Kayanza and resulting improvement of services; great stories of women who decided to adopt FP methods in Karusi; and the impact of IHPB-donated incubators in saving lives of newborn at Kirundo Hospital. Eric, a father of one of the saved children confided: *"Without the incubators, my son IRIHO would not be alive today."*

IHPB began designing a clearer communication and documentation strategy, as well as producing communication materials for partners to better understand IHPB expectations and limits. The project will continue these efforts in earnest in Y4.

Program Monitoring and Evaluation

Planned for Y3	Achievements and results	Comments
Conduct quarterly PEPFAR and project reporting	Achieved (100%)	APR FY 2015, Q1 FY2016, SAPR 2016, Q3 2016 timely submitted
Conduct an internal workshop on project monitoring, data quality assurance and data use -30 technical officers attend	Achieved (146%)	44 technical officers attended the workshop

Complete quarterly PEPFAR and project reporting

IHPB timely submitted, through DATIM, required PEPFAR reports: Annual Performance Results (APR 2015) on October 31, 2015, FY 2016 Semi-Annual Program Results (April 29, 2016), quarter 3 quarter 4 reports IHPB prepared and submitted the PEPFAR semi-annual report through DATIM (April 2016) in a timely manner. In addition, the contractual January-March 2016 quarterly report was submitted on time (April 29, 2016) and monthly progress reports (April, May, and June 2016) were submitted no later than the second working day of each following month.

Conduct an internal workshop on project monitoring, data quality assurance and data use

To strengthen the capacity of project staff, IHPB conducted:

(a) A two-day workshop attended by 9 IHPB staff whose objective was to present the new PEPFAR paradigm (PEPFAR 3.0) and the UNAIDS Fast Track strategy towards elimination of HIV transmission by 2030.
(b) A workshop on project monitoring, data quality and data use (La Détente, March 10-12, 2016). The 44 attendees included all project field office managers (4), senior technical officers (14), all technical program officers (12), and all M&E technical officers and data entry associates (10). The workshop was co-facilitated by the project's Senior Technical Advisor and the Data Systems Manager. Topics covered included the project's M&E Indicators, data demand and use, data quality, and data analysis.

At the end of the workshop, some resolutions were reached:

1) Develop a project information flow chart between field offices and the project country office;
2) Use dashboards to improve monitoring of key indicators
3) Pull together all project-specific data collection tools to improve data tracking;
4) Adopt a culture of written and clear data demand;
5) Establish a monthly DQA planning meeting;
6) Establish a monthly data analysis meeting;
7) Improve the quality of the project-supported district analysis workshops

Conduct IHPB Program and Technical Quality Assessment (PTQA)

In addition to routine M&E activities, with support from seven FHI 360 and Pathfinder HQ staff, IHPB conducted a two-week Program and Technical Quality Assessment (PTQA). The PTQA objective was to collaboratively explore and identify essential means to strengthen the project management and technical quality of the IHPB project. Specifically, the PTQA exercise helped to identify the project's greatest management and technical strengths; identify the project's highest priority project management and

technical challenges and opportunities of improvement; and develop a program and technical quality improvement plan (PTQIP) that readily addresses the project's highest priority challenges and needs and promotes its greatest strengths over the next 12 months. As part of the PTQA recommendations, IHPB conducted a three-day working session of the M&E Technical Officers in order to improve their understanding of the Performance Indicator Reference Sheets (PIRS) and updated the Performance Monitoring and Evaluation Plan accordingly.

Program Management

Planned for Y3	Achievement and results	Comments
Recruit and post additional staff as necessary	16 additional staff hired in Y3 including CoP.	Obtained USAID approval for hiring CoP – who reported to report to duty in August 2016
Submit monthly, quarterly, and annual reports	Achieved	12 monthly, three quarterly reports, one annual report, and PEPFAR reports including Y3 work plan submitted
Bujumbura-based staff conduct support visits to sub-offices	Achieved	
Hold quarterly staff planning and management meetings	Achieved	
Prepare for and convene Program and Technical Quality Assessment (PTQA)	Achieved	PTQA conducted with in-country support from 5 FHI 360 Home Office and 2 Pathfinder International staff. See Annex II for Home Office staff that participated in PTQA
Develop Y4 work plan, present to MPHFA and partners and submit to USAID	Achieved	Planning workshop held in August. See Annex II for Home Office staff that participated in Y4 work plan development
Submit Y4 work plan	Achieved	Submitted on August 31, 2016
Participate in collaboration, coordination and partnership-building meetings at the national and field office levels	Achieved	See Annex III

Recruit and post additional staff as necessary

By the end of September 2016, IHPB had a total of 77 staff – 64 FHI and 13 Pathfinder – of these, 16 were newly hired (12 FHI and 4 Pathfinder). Also, FHI 360 identified a Chief of Party (CoP) and after obtaining USAID concurrence, the CoP reported to post in August 2016.

Submit monthly, quarterly, and annual reports

During the reporting period, as required by the IHPB contract, FHI 360 submitted 12 monthly progress reports (October 2015 – September 2016); three quarterly reports (October 2015 – December 2015, January – March 2016 and April – June 2016); annual report (January 1, 2015 to September 30, 2015); and PEPFAR Annual Program Results. The monthly, quarterly and annual reports present achievements during the report period. Y3 work plan was also submitted and after recommended revisions by USAID, approval of the work plan was granted on November 23, 2105.

Bujumbura-based staffs conduct support visits to sub-offices

Senior staff including the DCoP, Senior Leadership Team members, and other technical specialists and advisors conducted support supervision visits while key project activities were underway: trainings on CCM of malaria, QI/QA and integration; strengthening capacity of community structures; basic emergency and neonatal care; modern contraceptive technology; building capacity of civil society organizations; and other trainings.

Hold quarterly staff planning and management meetings

During the reporting period, under the leadership of the Deputy Chief of Party, or Chief of Party, the five-member Senior Leadership Team (Deputy CoP, Associate Director of Finance & Administration, the Senior Technical Advisor of Health Systems Strengthening, the Senior Technical Advisor of Monitoring and Evaluation, and the Integrated Services Advisor held regular weekly meetings to make strategic decisions and monitor program implementation including coordinating with USAID, GOB entities and other USG partners. Under the leadership of a Field Office Manager, technical teams also held regular meetings with their respective staff in their respective offices.

Prepare for and convene Program and Technical Quality Assessment (PTQA)

With support from four FHI 360 and two Pathfinder Home Office staff, IHPB conducted an intensive two-week PTQA in May 2016. The following technical areas were assessed:

- HIV Clinical Care & Prevention of Mother-to-Child HIV Transmission (PMTCT) services,
- Maternal, Neonatal & Child Health (MNCH),
- Malaria,
- Reproductive Health (RH) & Family Planning (FP) services,
- Quality Assurance/Quality Improvement (QA/QI),
- Health Systems Strengthening (HSS),
- Provincial-Based Management System,
- Human Resources for Health/Supply Chain Management (HRH/SCM),
- Monitoring & Evaluation (M&E), and
- Project Management.

The PTQA mission was led by technical experts from FHI 360 Global Health, Population and Nutrition (GHPN) and program management experts from Platform and Portfolio Management (PPM), in close collaboration with IHPB leadership and staff in country and Pathfinder International staff from other programs. An intensive two-week country visit was convened in May 2016 for the assessment of all aforementioned components.

Develop Y4 work plan, present to MPHFA and partners and submit to USAID

On August 31, 2016, IHPB submitted Y4 work plan (October 1, 2016 to September 30, 2017) for review and approval by USAID. After approval, IHPB will convent and present its activities to the MPHFA and partners. It is important to note that during the development of the work plan, central and peripheral structures of the MPHFA were consulted.

Participate in collaboration and coordination meetings

During the reporting period, IHPB fostered collaboration and coordination with USG-funded projects and organizations and MPHFA. Annex III presents key events and meetings attended by project staff.

In addition, within the framework of IHPB staff capacity building, (a) Child Health Specialist, who is also Community Systems Strengthening Specialist, attended a two-week (July 18 to August 2, 2016) Summer Institute at Pathfinder (SIP) whose theme was "*Strengthening Community Heath Programs - Diagnosing Difficulties and Sharing Successes*" (b) Field Office Manager for Kirundo Province participated in the 2016 Global Technical Workshop on HIV Prevention, Care and Treatment & Orphans and Vulnerable Children (September 5-7, 2016, Lusaka, Zambia) organized by FHI 360 that brought together technical staff from across FHI 360 projects and countries come to share knowledge and experiences, and keep up to date with state of the art and international guidelines.

Problems Encountered/Solved or Outstanding:

Achievements registered in Y3 can be attributed to the close working relationships with the central and peripheral structures of the MPHFA; quality and timely technical assistance from IHPB home office staff; and timely response to IHPB requests by USAID. However, in achieving the planned activities, IHPB encountered challenges that include:

- The low number of health promotion technicians was an obstacle to conducting field-supervision of CHWs. In fact, a low ratio HPT/CHWs (1/129 in Vumbi health district) entails the inability for the HPT to conduct a supervisory visit to each CHW; they only organize monthly meetings for all the CHWs at health center level.
- The unavailability of district staff made difficult to conduct the planned quarterly visits to CHWs and COSA at health center level, obliging us to organize the activity at commune level where we could gather several health centers at the same time.
- Community health actors (CHWs and COSA members) do not meet the defined requirements especially the education level; some of them are illiterate and could not follow the different trainings organized for them.
- Conflict of agenda at district level: health district staff unavailability resulted in delaying activities with some trainings were conducted just at the end of the year; so consequent supervisory activities were not achieved. There are many activities that are not planned but that districts perform in addition to the planned activities.
- Stocks out of malaria commodities have been frequent during FY3. A shortage of ACTs and RDTs (ACT: 2-11 month) in April; ACT: 2-11month, 1-5 years in May and all over August month and half of September 2016 at national level.
- Stock out of reagents for early infant diagnosis (EID).

Annex I: Success Stories:

Success stories on the increase in numbers of women adhering to contraception:

In Karusi Province, only about 1 in 4 women are currently using contraception, compared with about 31% nationally. Given that the vaccination coverage in Burundi covers 89 percent of the population, there is a missed opportunity for reaching women and families with family planning information where they are, in their homes and in their communities. By utilizing the extensive reach of these vaccination campaigns, we can increase awareness of the benefits of FP and contraceptive methods that are available to clients at the local health centers, should they choose to use them. Likewise, counseling mothers on HIV prevention and care contributes to improved adherence to HIV services.

Buhiga and Nyabikere health districts, located in Karusi, have been co-piloting the integration of FP into MNCH services. After one year of implementation, the results are extremely encouraging; women are becoming more aware of the integral factors that affect their health, and are changing their mindsets about family planning. The pilot integration includes implementation of the quality improvement model, behavior change communication and education, and monitoring of progress through IHPB supportive supervision. Most importantly, access to FP has reached and maintained an adequate level in the project-support facilities.

BUHIGA HEALTH DISTRICT, BURUNDI: Ndikumana Léonie is a 35-year old married woman from Kabwira sub-hill in Buhiga health district (HD). During a supportive supervision visit to Bhuiga HD, the IHPB Program Technical Officer met Léonie and found her story compelling.

"When I came to the health center for the pregnancy test and my first antenatal consultations, I followed collective health education sessions on the benefits of contraception. Every time I got pregnant I went there and it was the same story. The last time, I was not very happy to have a 4th pregnancy. I was worried because I wished I had only 3 children."

"These health educational sessions that I repeatedly followed have opened my eyes on the best way to avoid another pregnancy. I realized that I was not good at monitoring my periods. The only and easiest way for me to be confident [that I would not get pregnant again] was contraception. I told my husband and he was very supportive. Thus, after delivery, I came back at the health center for vaccination of my little baby. After the nurse has taken care of my child, I asked her if I could get contraception. She smiled and explained to me once again many sorts of methods. I quickly chose the injection and got it right there. She took very good care of me and I returned home very happy."

"Life is very difficult nowadays and 4 children are already a very heavy burden. It is very hard to nurture them and attend to all of their needs. And about this contraception, I have already spent 4 months on it and do not have any problems. Some people in the neighborhood were afraid because they had some misconceptions about contraception. I always tell them that it is a very good choice if they want healthier children. I also teach them that many pregnancies can weaken a woman's health. Some of my neighbors have already followed my advice and they are all doing well today."

Other stories like Léonie's have been heard at Masabo HC and Rusamaza HC, in Nyabikere HD.

NYABIKERE HEALTH DISTRICT, BURUNDI: Sylvie Manirakiza, a young woman living at Muzenga sub-hill, and married with two children, tells the following story:

"*I brought my child to the health center as he had fever. Once at the HC, I sat down with other clients in the waiting hall, and there was a collective health discussion session taking place nearby. Among other health topics, the leaders were reminding those of us at the session about contraception and its benefits. That day I was enlightened, I understood the benefits of having contraception. Even though this was not what had brought me to the HC that day, I decided to ask for contraception right after they finished taking care of my child. The nurse explained to me that there are many kinds of contraceptive methods one may use and I chose to have an injection. The injection was administrated to me that day before I returned home. I am comfortable with it and have never experienced any bad [side] effects, contrary to what I used to hear other people say. I want to have three children in total and I believe that I will reach my goal if I keep using contraception*."

Success stories on community management of acute malnutrition at community level.

Since 2013, the USAID-funded Integrated Health Project in Burundi (IHPB) has supported health facilities to respond to the strengthening health systems and fill community needs, especially quality healthcare, by providing capacity building, equipment, coaching, and supportive supervision in four target provinces. IHPB has identified a crucial opportunity for strengthening Burundi healthcare system by involving communities at the most fundamental level. Among other approaches, IHPB has focused on the management of acute malnutrition at the community level.

The 2010, the Burundi DHS showed that 65 percent[16] of the population suffers from either chronic, acute, or severe acute malnutrition. While other provinces had support from various partners to fight against malnutrition, Nyabikere health district lacked similar support to combat malnutrition in its supported area. The routine screening for malnutrition conducted by CHWs from October 2015 to August 2016 show 6 percent for mild acute malnutrition and 2 percent for severe acute malnutrition.

IHPB realized that the district's response to this problem is limited by decreased focus on training related to screening, awareness of referral systems, and education. In response, the project invested resources and efforts in training 186 CHWs, 18 health center chiefs, and seven health promotion technicians on the community-based management of acute malnutrition. Some challenges are prevailing: many HCs are not accredited with services for all categories of malnutrition and sometimes do not have material and equipment to manage malnutrition cases, (e.g. therapeutic foods). Therefore, the trained CHWs must depend on locally produced foods to support these children's caregivers in combatting malnutrition.
During supportive supervision, IHPB has documented the progress and followed success stories from the community. These stories emphasize how community case management of acute malnutrition is impacting lives of women in Karusi.

[16] 58 percent suffer from malnutrition, 6 percent suffer from acute malnutrition, and 1 percent suffer from severe acute malnutrition. DHS 2010.

KAYOGORO, BURUNDI: Jacqueline Nkunzimana is a 30-year-old farmer and already has five children. "I saw my child progressively losing weight and becoming increasingly fragile with a chronic cough. Several times, I suspected malaria but the results were negative. My child had become different, unrecognizable. Nobody understood what he was suffering from. I never thought that it would be malnutrition because I breastfed him normally. Unexpectedly, our CHW visited me, and asked me if he could test my child. Right after the screening, he showed me a red color and told me it was malnutrition. He asked me to bring the child to Gihogazi HC so that he could be taken care of. It was very far away from my home. I went there 3 times, but all were in vain. The nurses told me twice that they did not have nutritional commodities, and the last time I went there they refused to help me as I did not have my health insurance card. I was frustrated, worried, and desperate. I was also tired because of the long days of travel. I returned to the CHW and told him. He understood and advised me not to be discouraged. He told me that he could help me. He started by teaching me how I should prepare foods for my child, especially foods that I could afford such as vegetables, peanuts, beans, etc. and some meat when I able to get it. After a while, I saw my child's health improving. He used to get sick 2 to 3 times a month, and sometimes hospitalized, but from the time I started following the CHW's advice 3 months ago he has been doing very well. He's no longer sickly. I continue to prepare foods in a balanced way, with vegetables that I grow myself and peanuts, etc. And sometimes when I get some money, I buy some meat. I noticed that we often have useful foods at home but do not know how to prepare them. Today, I teach other women in my neighborhood how to cook food that keeps our children healthy. My baby boy, Faustin Twagiramungu, was a skinny 1 year-and-8-month old, but thanks to the advice from our CHW he is now a gentleman of 2 years-and-2 months old".

Upon hearing Jacqueline's story, the IHPB team visited Maurice Biraronderaw, the CHW responsible for the Kayogoro zone, located in Nyabikere Health District.

NYAMIYAGA, KARUSI: Maurice Biraronderwa has been a CHW since 2004. He is 42 years old and lives at Nyamiyaga Hill of Kayogoro zone; he is married and has 6 children. IHPB trained and continues to support Maurice, who focuses his work on helping mothers keep their children health and combat severe malnutrition.

"After the training I had on the management of acute malnutrition by IHPB, I was aware that there might be some cases in the era of my responsibility. Among other cases I suspected, there was this case of Jacqueline. In my routine visit, I approached her and asked if I could do the test. When I took the MUAC (mid-upper arm circumference) measurement, it turned red in color, indicating severe acute malnutrition. I quickly referred the case to Gihogazi health center where she could find medical help and commodities. She went 3 times, twice experiencing a lack of commodities, and once she was turned away because she did not have health insurance. She explained to me that the nurses clearly warned her that without health insurance she would not be helped at the HC. She was

desperate and I found that unfortunate and unfair. The distance from her home to Gihogazi was very far and I had pity for her. I, myself walk two hours and fifteen minutes to Gihogazi. I imagined the burden for her with a baby on her back and felt compassion. As I was trained by IHPB, I decided to help her myself. I started by teaching her how she could balance her baby's diet in combining different sorts of foods that are rich in protein, fats, and carbohydrates, and how she could cook them mixed or separately. I used simple foods that she could get at home, and advised her to by meat whenever she could. After 4 months, there was positive progress: I took the MUAC again and it showed yellow color, meaning the child no longer had severe acute malnutrition. Additionally, the baby had increased in weight and looked much better. As you can see, the baby is doing well and I am following up to see him completely recovered."

Annex II: STTA

Name	Title	Dates	Purpose
Tracy Orr	Technical Officer – Gender (FHI 360)	July 11 – 19, 2016	Finalize IHPB gender strategy and train IHPB staff on gender integration
Bruno Bouchet	HSS Director (FHI 360)	May 14-27, 2016	Participate in the Program Technical and Quality Assessment (PTQA)
Rachel Deussom	Human Resources for Health Specialist (FHI 360)		
Philippe Sanchez	Senior Program Officer (FHI 360)		
Gina Etheredge	Senior Advisor – M&E (FHI 360)		
Saintely Dubisson	Technical Director – Haiti (Pathfinder)		
Marie-Claude Mbuyi	Technical Director – DRC (Pathfinder)		
Walarigaton Coulibaly	Associate Director, Eastern and Southern Region (FHI 360)		
Peter Gottert	Consultant SBCC Specialist (FHI 360)	June 23 to July 11, 2016	Provide technical assistance in the area of SBCC
Bruno Bouchet	HSS Director (FHI 360)	August 9-26, 2016	Participate in the overall IHPB Y4 work plan development and provide technical assistance in their respective areas of technical expertise
Rachel Deussom	Human Resources for Health Specialist (FHI 360)		
Philippe Sanchez	Senior Program Officer (FHI 360		
Gina Etheredge	Senior Advisor – M&E (FHI 360)		
Stephen Redding	Senior Advisor for Strategic Initiative (Pathfinder)		
Megan Averill	Senior Technical Officer HSS (FHI 360)		
Alison Gatto	Senior Program Officer (Pathfinder)		
Candace Lew	Senior Technical Advisor – Contraception (Pathfinder)		
Camille Collins Lovell	Technical Advisor- Community Engagement (Pathfinder)		

Annex III- Collaboration and coordination meetings attended

Date	Title of IHPB Staff Member	Theme of Meeting/Event
October 1, 2015	Child Health Specialist	Preparations for a study to assess needs for setting up community health information system (first meeting)
October 1, 2015	Supply Chain Management Specialist	Exchange on activities carried out within the framework of the implementation Logistics Management Information System
October 14, 2015	Deputy Chief of Party	Launching of the PNSR's 2015-2020 work plan
October 22,2015	Child Health Specialist	Preparations for a study to assess needs for setting up community health information system (second meeting)
October 22,2015	Integrated Health Services Advisor	Coordination meeting for the implementation of the Burundi HIV/AIDS health sector operational plan
November 26, 2015	Deputy COP and Malaria Specialist	PMI implementing partners meeting
December 4, 2015	Deputy Chief of Party	Courtesy call to the Minister of the MPHFA
December 4, 2015	Child Health Specialist	Validation workshop of the National Strategic Plan for child survival
January 27, 2016	Capacity Building Advisor	Urgent meeting on the management of outbreak of malaria led by the MPHFA
January 29, 2016	Maternal Health specialist	Meeting on activities planning related to training on BEmONC and contraceptive technologies led by PNSR
February 8 and 11, 2016	Capacity Building Advisor	Meeting on the management of outbreak of malaria led by the MPHFA
February 24, 2016	Capacity Building Advisor	Meeting on the preparation of the workshop on the involvement of CSOs in the Country Operational Plan (COP) FY 16 process including USAID (PEPFAR) UNAIDS, PMTCT and IHPB projects
February 24-27, 2016	Health Integrated Services Advisor	Workshop to write operational plans for the Global Fund to Fight AIDS, Tuberculosis and Malaria Burundi Grant
February 25, 2016	M&E senior technical advisor, MH specialist	Meeting with Measure Evaluation to discuss on gender issues
March 10 , 2016	Maternal Health specialist	Workshop on EONC training approach and AMTSL algorithm validation led by PNSR
March 10, 2016	Capacity Building Advisor	Workshop to raise CSO contributions for COP 16
March 17-18, 2016	MH specialist	Coordination meeting for PNSR partners organized by PNSR
March 23, 2016	Supply Chain Management Specialist	Technical meeting organized by the MHFA
March 24 and 31, 2016	Malaria specialist	Preparation for the 9th World Malaria Day.
April 20, 2016	Malaria Specialist	Coordination meeting organized by National Malaria Control Program (NMCP)
April 29, 2016	Capacity Building Advisor	Celebration of the ninth day of global fight against malaria

Date	Title of IHPB Staff Member	Theme of Meeting/Event
May 4, 2016	Capacity Building Advisor	Meeting on the health book mother-child leaded by the Direction of Demand and Delivery care in the Ministry of Public Health
May 10, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)
May 11 - 13, 2016	MH specialist	Regional workshops on maternal death surveillance organized by PNSR
May 17, 2016	Director of HSS at FHI360 HQ; Senior Program Officer, Platform and Portfolio Management at FHI360 HQ; IHPB DCOP; IHPB Capacity Building Advisor	Audience with the Minister of Public Health and Fight against AIDS on the PTQA objectives and results
May 30 - June 9, 2016	MH specialist and Muyinga FOM	Training of trainers on SGBV organized by BRAVI in partnership with PNSR
June from 6 to 10, 2016	Integrated Health Services Advisor	Workshop for adaptation of new WHO 2015 guidelines on prevention and treatment of HIV infection
June 8, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)
June 13, 2016	Acting COP; M&E Specialist; Integrated Health Services Advisor.	USAID implementing partners meeting
June 13, 2016	Capacity Building Advisor	Workshop on the implementation of the 'Linkages Project'
June 24, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)
July 11-15, 2016	Supply Chain Management Specialist	Workshop for data analysis specialist and procurement plan update
July 14, 2016	Capacity Building Advisor and Malaria Specialist	Meeting with the Director of Supply and Demand for care in the Ministry of Health, on the implementation of iCCM in Musema district when another partner wishes to work in the same district
July 21, 2016	Maternal Health Specialist	Meeting on the commission for introduction of cervical cancer vaccine
August 3, 2016	Integrated Health Services Advisor	PEPFAR Implementing Partners
August 4, 2016	Maternal Health Specialist	Meeting on the commission for introduction of cervical cancer vaccine
August 11, 2016	Integrated Health Services Advisor	Exchange of Experience meeting with EQUIP Consultants
August 23, 2016	SBCC Program Officer	AGASHI I closeout and launch of AGASHI 2, a serial radio drama implemented by Population Media Center.
August 25, 2016	Maternal Health Specialist	Meeting on the commission for introduction of cervical cancer vaccine
August 31, 2016	Capacity Building Advisor	PEPFAR workshop on Country Operational Plan 2017 for CSOs

Date	Title of IHPB Staff Member	Theme of Meeting/Event
September 1, 2016	Integrated Health Services Advisor	Review of National New Guidelines for HIV prevention and treatment
September 5, 2016	SBCC Program Officer	Preparatory meeting for the contraception World day organized by the National Program of Reproductive Health (PNSR)
September 5-6, 2016	Integrated Health Services Advisor	Technical Assistance interview for management team of GF HIV/AIDS
September 6, 2016	SCM Specialist	Rapid Test distribution meeting in PEPFAR focus area
September 9, 2016	Integrated Health Services Advisor	Validation meeting of National New Guidelines for HIV prevention and TH
Septembre 12-16, 2016	M&E Technical Officer	Community HIS tools validation workshop
September 19, 2016	Maternal Health Specialist	Meeting on the preparation for World Contraception Day
September 20, 2016	Maternal Health Specailist	GBV training guide validation workshop
September 27, 2016	SCM Specialist	Chemonics/PSM planification and prioritisation activities
September 28, 2016	Integrated Health Services Advisor	Procurement of Rapid Test of PEPFAR
September 30, 2016	Maternal Health Specialist	Participation in World Contraception Day celebration

Annex IV– HIV services Progress in Kayanza Province

PEPFAR Indicators	Target FY 2016	Q1(Oct-Dec 2015)			Q2 (Jan-Mar 2016)			Q3 (Apr-Jun 2016)			Q4 (July-Sept 2016)			Oct 2015- Sept 2016		
		Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%	Target FY 2016	Achie-vement	%
Number of individuals who received HTC services and their test results	92,939	23,235	37,286	**160%**	23,235	43,764	**188%**	23,235	44,995	**194%**	23,235	29,778	**128%**	92,939	155,823	**168%**
Number of HIV positive individuals	2,600	650	125	**19%**	650	139	**21%**	650	131	**20%**	650	566	**87%**	2,600	961	**37%**
Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	125	31	54	**173%**	31	53	**170%**	31	54	**173%**	31	48	**154%**	125	209	**167%**
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	112	28	31	**111%**	28	39	**139%**	28	52	**186%**	28	39	**139%**	112	161	**144%**
Number of people receiving post-GBV care	18	5	13	**289%**	5	9	**200%**	5	14	**311%**	5	14	**311%**	18	50	**278%**
Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS (DSD)%																
Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load	2,640	660	60	**9%**	660	198	**30%**	660	93	**14%**	660	251	**38%**	2,640	602	**23%**
Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	4,705	2,725	2,498	**92%**	3,385	2,730	**81%**	4,045	2737	**68%**	4,705	2,855	**61%**	4,705	2,855	**61%**
Number of adults and children newly enrolled on ART	2,335	584	74	**13%**	584	189	**32%**	584	147	**25%**	584	195	**33%**	2,335	605	**26%**
Number of adults and children receiving ART [current] (TA-only)	4,016	2,265	1,389	**61%**	2,849	2,210	**78%**	3,432	2,260	**66%**	4,016	2,498	**62%**	4,016	2,498	**62%**

Annex V – HIV services Progress in Kirundo Province

PEPFAR Indicators	Target FY 2016	Q1(Oct-Dec 2015)			Q2 (Jan-Mar 2016)			Q3 (Apr-Jun 2016)			Q4 (July-Aug 2016)			Oct 2015- Sept 2016		
		Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%	Target	Achie-vement	%	Target FY 2016	Achie-vement	%
Number of individuals who received HTC services and their test results	45,109	11,277	33,823	300%	11,277	37,799	335%	11,277	30,088	267%	11,277	28,138	250%	45,109	129,848	288%
Number of HIV positive individuals	1,540	385	402	104%	385	715	186%	385	489	127%	385	2016	524%	1,540	3,622	235%
Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	367	92	153	167%	92	196	214%	92	170	185%	92	163	178%	367	682	186%
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	331	83	11	13%	83	84	102%	83	101	122%	83	146	176%	331	342	103%
Number of people receiving post-GBV care	18	5	17	378%	5	17	378%	5	13	289%	5	18	400%	18	65	361%
Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS (DSD)%	2,448	612	639	104%	612	1,141	186%	612	951	155%	612	803	131%	2,448	3,534	144%
Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load	1,484	371	188	51%	371	683	184%	371	463	125%	371	744	201%	1,484	2,078	140%
Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	3,730	2,617	4451	170%	2,988	4,659	156%	3,359	4531	135%	3,730	4,962	133%	3,730	4,962	133%
Number of adults and children newly enrolled on ART	1,388	347	97	28%	347	701	202%	347	436	126%	347	522	150%	1,388	1,756	127%
Number of adults and children receiving ART [current] (TA-only)	3,184	2,143	2417	113%	2,490	2,911	117%	2,837	3,479	123%	3,184	3,575	112%	3,184	3,575	112%

Annex VI. PMEP Indicators Achievements, Y3

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
HIV/AIDS Indicators									
1.3.4 Number of persons receiving post GBV care (Post-rape care, other post-GBV care, PEP) [GEND_GBV]	Quarterly	102	150	30	26	27	56	139	93%
1.3.5 Number of facilities that provide PEP to GBV survivors	Quarterly	7	27	23	23	23	26	26	96%
2.0.3 Number of individuals who were referred to and received other health and non-health services [MR]	Quarterly	7,137	18,200	6,913	4,389	4993	4199	20464	112%
2.0.7 Number and percent of pregnant women with known HIV status PMTCT_STAT] [MR]	Quarterly	94% 127,306/135626	95%	89.7% (15,785/17,751)	90.1% (14877/16514)	87.5%[17] (13,048/14,906)	90.6% (13696/15109)	89.3% (57406/64280)	94%
2.0.8 Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-childtransmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV] [MR]	Quarterly	93% 957/1028	95%	96.2% (205/213)	98.4% (240/244)	90.2% (219/246)	86.4% (197/228)	92.5% (851/920)	97%
2.0.9 Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST]	Quarterly	360,446	138,048	71,109	81,563	75,075	94197	321944	321%
2.0.10 Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR]	Quarterly	10071	8,435[18][19]	7030	7,389	7,179	8033	8033	95%

[17] Lower performance than previous quarter because throughout April 2016, sites in Mukenke District stopped tested assuming that available kits of Determine were deteriorated.

[18] PEPFAR reduced coverage zone from 4 to 2 provinces

[19] 155 PLHIV were referred from Kirundo Hospital to Kagari HC in Muyinga province, 42 referred from Rubura HC to Mparamirundi HC in Ngozi Province, 53 lost-to-follow up, 5 deceased 10 Performance Indicator Reference Sheet target for FY2016

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
2.0.11 Percent of HIV-positive positive patients who were screened for TB in HIV care or treatment setting [PEPFAR TB_SCREEN]	Quarterly	12,8%	50%[10]	47% (3301/7030)	59.4% (4,392/7,389)	67.9% (4,875/7,179)	62.2% (4942/7943)	61.7% (4961/8033)	123%
2.0.12 Percent of infants born to HIV positive women that receive a virological HIV test within 12 months of birth [PEPFAR PMTCT_EID]	Quarterly	31% (314/1028)	61%[2]	22% (46/213)	54% (132/244)	62% (153/246)	29% 67/228	45% (412/924)	73%[20] (45%/61%)
2.0.13 Number of adults and children receiving ART (TA only) [PEPFAR TX_CURR]	Quarterly	4996	7,200[2]	3808	5,121	5,701	6211	6211	86%
2.2.2 Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services [PEPFAR FPINT_STE]	Quarterly	26% 45/173	63%	57% (53/93)	64.2% (61/95)	70.5% (67/95)	74.7%(71/95)	74.7% (71/95)	119%
3.1.3 Percent of supported facilities that have the capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	Annually	66.7% (6/9)	80%	NA	NA	NA	NA	100%(5/5)	125%
3.3.3 Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS [PEPFAR OVC_SERV_DSD]	Quarterly	11,9358	2,488	639	1141	951	1425	1924	79%
Malaria indicators									
2.0.14 IPTp2 under direct observation of a health worker	Quarterly	NA7	70%	48.9% (10,192/20,853)	64.0% (30,405/47,502)	79.6% (19,640/24,659)	80.7% (16189/20064)	67.6% (76426/113078)	97%
2.0.15 Proportion of pregnant women attending ANC who received ITNs	Quarterly	80.3% 116160/144739	94%	77.1% (17,858/23,164)	83.3% (19,350/23,212)	80.3%[21] (16,409/20,424)	82.2% (17101/20804)	80.7% (70718/113078)	86%

[20] Full achievement was reached because

[21] Performance is lower than last quarter when there was a malaria outbreak.

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
2.0.16 Proportion of children under five with fever who received ACT within 24 hours of onset of fever	Quarterly	66.6% 20666/31060	75%	84.6% (28,324/33,482)	74.7% (25,150/33,676)	68.6%[22] (24,060/35,062)	68.3% (25181/36891)	73.8% (102715/139111)	98%
2.0.16a Proportion of children under five RDT positive who received ACTs				100.0% (28,324/28338)	97.5% (28,260/28,971)	99.9% (26,182/26,192)	98.2% (27621/28132)	98.8% (110387/111633)	98.8%
2.1.2 Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women) [MR]	Quarterly	NA	62,000	Treated 26,486 Referred 5991	Treated 28,260 Referred 5,692	Treated 26,182 Referred 9,112	Treated 27621 Referred 10319	Treated 108549 Referred 31114	225%[23]
MNCH Indicators									
2.0.4 Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs [3.1.6-61]	Quarterly	81.9% GESIS 2013	82%	92.5% (16865/18231)	91.7% (16,719/18,231)	102.3% (18,655/18,231)	102.1% (18624/18231)	97.2% (70863/72924)	118%
2.0.5 Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs [3.1.6-64]	Quarterly	8.8%	18%	56.2% (6,066/10,795)	78% (10,690/13,695	85% (12,006/14,122)	82.4% (12778/15509)	76.8% (41540/54121)	427%[24]
2.0.6 Number/percent of women reached with education on exclusive breastfeeding	Quarterly	NA	115,000	41,743	42,363	48,701	78479	211286	184%[25]
Reproductive Health and Family Planning Indicators									
1.2.2 Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide [FP/RH 3.1.7.1-2]	Quarterly	37.6%	0%	28.2% (42/149)	4.1% (6/147)	6.1% (9/147)	17% (25/147)	14% (20/147)	130%[26]

[22] There was a stock out of ITNs from mid-April through mid-June 2016.

[23] IHPB accelerated implementation of CCMM and iCCM and achieved more than targeted

[24] With available funds and high rate of maternal mortality due to hemorrhage as informed by maternal death audits, IHPB was able to quickly scale up.

[25] Activities were scaled up during Y3

[26] This is a negatively formulated indicator. So, for a target of 20%, 13.6% is an achievement rate of 130% using following formula [1+((20%-13.6%)/20%)].

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
2.0.1 Couple years of protection rate for family planning [3.1.7.1-1] [Mandatory Result]	Annually	186,249	136828					132567	97%
Gender/GBV indicators									
1.3.1 Number of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalance within the household) [MR]	Annually	0	4	0	0	1	2	3	75%
1.3.2 Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products [Mandatory Result]	Annually	0	1					0	0%[27]
Health Systems strengthening indicators									
1.1.4 Number of health communication materials developed, field tested, and disseminated for use	Annually	2	4					21	525%[28]
1.2.1 Percent of supported facilities that experienced a stock-out at any point during the last three months [MR]	Quarterly	62%	55%	64.6% (106/164)	64.3% (104/164)	39% (64/164)	62.1% (102/164)	57% (94/164)	96%[29]
2.1.1 Percent of supported health centers with CHWs that provide the core package of quality integrated health and support services [Mandatory Result]	Baseline Mid-term End-term	0%	5%	NA				36.1%	720%[30]
2.1.3 Percent of health centers that have functional CHW systems	Annually	11% (16/146)	16%					N/A	NA[31]

[27] One district is already targeted and GBV activities were initiated. To complete the package, male involvement activities will be added in Y4 once the project gender strategy is validated.

[28] IHPB strategized to hire additional consultant to help in the development of communication materials to accelerate community activities with CHW's resulting in the development of 21 materials.

[29] The target for this indicator is negative (-10%). So, for a target of 55%, 57% is an achievement rate of 96% with following formula [1+((55%-57%)/55%)].

[30] Training and coaching of CHWs networks allowed to achieve more than planned for mid-term.

[31] Awaiting to access PBF data

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
2.1.4 Percent of COSAs that meet defined functionality standards	Annual	67.7%(111/164)	72.7%					61.1% (22/36)	84%
2.2.1 Percent of supported facilities that provide a core/expanded package of quality integrated health services [Mandatory Result]	Annual	**"Core" Services Available at Health Centers: 0% (0/164)** FH/RH: 32.3% (53/164) ANC: 0% (0/164) Maternal health: 18.3% (30/164) Well child: 79.9% (131/164) Child curative: 6.1% (10/164) HIV: 0% (0/164) PMTCT: 21.3% (35/164) Malaria: 83.5% (137/164) GBV: 13.4% (22/164) **"Expanded" Services Available at Hospitals : 0% (0/9**) FH/RH : 33.3% (3/9) Maternal health: 88.9% (8/9) Child curative: 6607% (6/9) HIV: 0% (0/9) PMTCT: 66.7% (6/9) Malaria: 100% (9/9) GBV: 33.3% (3/9)						**"Core" Services Available at Health Centers: 0% (0/164)** FH/RH: 58.3% (21/36) ANC: 91.7% (33/36) Maternal health: 41.7% (15/36) Well child: 86.1% (31/36) Child curative: 16.7% (6/36) HIV: 11.1% (4/36) PMTCT: 50.0% (18/36) Malaria: 97.2% (31/36) GBV: 77.8% (28/36) **"Expanded" Services Available at Hospitals: 0%** FH/RH: 22.2%) Maternal health: 100% (8/9) Child curative: 6607% (9/9) HIV: 33.3 % (3/9) PMTCT: 55.6%) Malaria: 100%) GBV: 44.4%	**NA**
2.2.3 Percent of supported facilities that perform to national technical and quality standards [Mandatory Result]	Annually	10% (16/153)	60%					N/A	NA
2.2.4 Percent of supported facilities that receive supportive supervision on a regular basis [Mandatory Result]	Annually	94% (155/164)	100%					78.0% (135/164)	78%

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
2.3.1 Percent of project-trained health providers, managers and CHWs who perform to a defined standard post-training [Mandatory Result	Annually	N/A	95%	0%	88,8% 24/27	100% (8/8)	90% (9/10)	91% (41/45)	96%
2.3.2 Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [MR]	Quarterly	N/A	90%	92.4% (n=497) 89.9% (n=217)	95.5% (n=943) 91.9% (n=149)	95.5% (n=1461) 98.0% (n=557)	95.0% (n=984) 91.4% (n=430)	94.6% (n=3885) 93.9% (n=1353)	104%
2.3.3 Percent of trained health care staff who report positive attitudes about work and the workplace [Mandatory Result]	Annual	56.7% (135/238)	62%					79.2% (84/106)	127%
2.3.4 Percent of supported facilities with at least 80% of clients reporting satisfaction with services received [Mandatory Result]		99%	100%					NA	N/A
2.3.5 Number of health care workers who successfully completed an in-service training program	Quarterly	NA	1940	594	423	574	241	94.4% (1832/1940)	94.4%
2.3.6 Number of community health/parasocial workers who successfully completed a pre-service training program	Quarterly	NA	1436	0	822	282	340	100.6% (1444/1436)	100.6%
3.0.1 Percent of the supported districts and/or communities with demonstrable links to or leveraging resources from non-USAID sources [Mandatory Result]	Annual	N/A	NA					58.3% (7/12)	58.3%
3.1.1 Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]	Annual	FP/RH : 16.2% (28/173) ANC : 8.1% (14/173) Maternal Health : 12.7% Child Health : 15.6% (27/173) HIV/AIDS : 0% (0/173) Malaria : 89% (154/173) GBV : 11% (19/173)	FP/RH 30%) ANC : 50% Maternal Health : 50%) Child Health : 30% HIV/AIDS : 50% Malaria : 89% GBV : 30%					FP/RH : 24.4% ANC : 37.8% Maternal Health : 48.9% Child Health : 26.7% HIV/AIDS : NA Malaria : 97.8% GBV : 33.3%	FP/RH : 80% ANC : 76% Maternal Health : 98% Child Health : 89% HIV/AIDS : NA Malaria : 110% GBV : 111%

Indicator	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016	July-Sept 2016	Annual	Achievement vrs target
3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result]	Annually	26.6% (46/173)	29.6%	NA	NA	NA	NA	51.1% (23/45)	172%
3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]	Annual	12	100%	100%	100%	100%	100%	100%	100%
3.2.1 Percent of facilities that maintain timely reporting [MR]	Quarterly	95% (165/173)	97.8%	100% (173/173)	100% (173/173)	100% (173/173)	100% (173/173)	100% (173/173)	100%
3.2.2 Percent of districts and facilities that demonstrably use facility- and community-level data for timely decision making [Mandatory Result]	Annually	Facility: 87.3% (151/173) Districts: 75% (9/12)						Facility :93.3% (42/45) District: 83.3% (10/12)	Facility:107% District: 111%

	≥ 125% of target achievement	9 indicators
	+/- 25 % of target achievement	29 indicators
	50-57% of target achievement	2 indicators
	< 50% of target achievement	1 indicator
N/A	Data not ready to inform the indicator	4 indicators